

## CERTIFICATE OF DEATH

12441

Reg. Dist. No. 145

12485

|   |                                  |   |  |   |  |   |  |
|---|----------------------------------|---|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Frederick</u> MARYLAND  |                                  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Md.</u> b. COUNTY <u>Frederick</u> |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Rural Myersville</u>   |                                  |   |  | c. LENGTH OF STAY IN 1b   |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION  |                                  |   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Rural Myersville</u>                             |  |   |  |
|   |                                  |   |  | d. STREET ADDRESS   |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Henry</u> Middle <u>B.</u> Last <u>Baker</u>  |                                  |   |  | 4. DATE OF DEATH<br>Month <u>12</u> Day <u>23</u> Year <u>1956</u>  |  |   |  |
| 5. SEX<br><u>male</u>   | 6. COLOR OR RACE<br><u>white</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>1904</u><br><u>2-9-1904</u>   | 9. AGE (In years last birthday)<br><u>52</u> yrs.   | IF UNDER 1 YEAR<br>Months Days Hours Min.                              |   | IF UNDER 24 HRS.   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>general laborer</u>   |                                  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>bakery</u>   |   | 11. BIRTHPLACE (State or foreign country)<br><u>Maryland</u>           |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.</u>  |
| 13. FATHER'S NAME<br><u>James E. Baker</u>  |                                  |   | 14. MOTHER'S MAIDEN NAME<br><u>Etta Summers</u>  |   |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><u>no</u>   |                                  | 16. SOCIAL SECURITY NO.<br><u>213-14-0396</u>   |  | 17. INFORMANT<br><u>Mrs. Jean Baker, Myersville Md.</u>   |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u><br><u>420.1</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |                                  |   |  |   |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>14 hrs</u>                                      |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  |   |  |   |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. <u>11</u> p. m. <u>19</u>  |                                  |   | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |   | 20f. (City or town) (County) (State)   |
| 21. I certify that I attended the deceased from <u>Dec 22</u> , 19 <u>56</u> , to <u>Dec 23</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Dec 22</u> , 19 <u>56</u> , and that death occurred at <u>Md.</u> from the causes and on the date stated above.   |                                  |   |  |   |  |   |  |
| ACTUAL SIGNATURE<br><u>J Elmer Harp</u>   |                                  |   |  | ADDRESS (Street, city or town, state)<br><u>Middletown</u>  |  |   |  |
| PHYSICIAN'S NAME (Type)<br><u>Gladhill Co. Middletown, Md.</u>  |                                  |   |  | DATE SIGNED<br><u>Dec 26-1956</u>   |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |                                  | 22b. DATE THEREOF<br><u>12/26/56</u>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Ch. of B. Cemetery</u>   |  | 22d. LOCATION (City, town, or county) (State)<br><u>Harmony (Fred. Co.) Md.</u> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Gladhill Co. Middletown, Md.</u>   |                                  |   |  | 24a. REC'D BY REGISTRAR<br><u>Dec 26-1956</u>   |  | 24b. REGISTRAR'S SIGNATURE<br><u>Floyd M. Bittel</u>                            |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

|                       |  |                  |  |             |  |                  |  |                  |  |                   |  |                   |  |                            |  |                            |  |                            |  |
|-----------------------|--|------------------|--|-------------|--|------------------|--|------------------|--|-------------------|--|-------------------|--|----------------------------|--|----------------------------|--|----------------------------|--|
| 1. Name of deceased   |  | 2. Sex           |  | 3. Age      |  | 4. Date of death |  | 5. Time of death |  | 6. Place of death |  | 7. Cause of death |  | 8. Manner of death         |  | 9. Signature of physician  |  | 10. Signature of registrar |  |
| John Doe              |  | Male             |  | 45          |  | Dec 28 1956      |  | 10:00 AM         |  | Home              |  | Heart Disease     |  | Natural                    |  | [Signature]                |  | [Signature]                |  |
| 11. Name of informant |  | 12. Relationship |  | 13. Address |  | 14. City         |  | 15. State        |  | 16. Zip           |  | 17. Date of birth |  | 18. Date of death          |  | 19. Signature of informant |  | 20. Signature of registrar |  |
| Jane Doe              |  | Wife             |  | 123 Main St |  | Baltimore        |  | MD               |  | 21201             |  | Jan 1 1911        |  | Dec 28 1956                |  | [Signature]                |  | [Signature]                |  |
| 21. Name of physician |  | 22. Address      |  | 23. City    |  | 24. State        |  | 25. Zip          |  | 26. Date of birth |  | 27. Date of death |  | 28. Signature of physician |  | 29. Signature of registrar |  | 30. Signature of informant |  |
| Dr. Smith             |  | 456 Oak St       |  | Baltimore   |  | MD               |  | 21201            |  | Jan 1 1911        |  | Dec 28 1956       |  | [Signature]                |  | [Signature]                |  | [Signature]                |  |

RECEIVED  
DEC 28 1956  
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12486

## CERTIFICATE OF DEATH

12442  
138

Reg. Dist. No.

|  |                                  |  |   |
|--|----------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Frederick</b> MARYLAND   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>             |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Frederick-Rural RD#6</b>  |                                  | c. LENGTH OF STAY IN 1b<br><b>3 Months</b>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Bartonsville Road</b>   |                                  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>LINDA</b> Middle <b>ANN</b> Last <b>BARTLETT</b>   |                                  | 4. DATE OF DEATH<br>Month <b>December</b> Day <b>31</b> Year <b>19 56</b>  |   |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>24 Sept 1956</b> |
| 9. AGE (In years last birthday) yrs. <b>3</b> Months <b>7</b> Days <b></b> Hours <b></b> Min. <b></b>  |                                  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Infant</b>  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Infant</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Maryland</b>   |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   |
| 13. FATHER'S NAME<br><b>James C. Bartlett</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Florence Trout</b>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)  |                                  | 16. SOCIAL SECURITY NO.<br><b>None</b>   |   |
| 17. INFORMANT<br><b>James C. Bartlett (Same as item #1)</b>  |                                  | Address  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c):]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Broncho Pneumonia</b><br><b>491X</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO<br>(c) _____ |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 day</b>   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. p. <b>19</b> p. m.   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)   |   |
| 21. I certify that I attended the deceased from <b>12-28</b> , 19 <b>56</b> , to <b>12-31</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>12-31</b> , 19 <b>56</b> , and that death occurred at <b>11:30 PM</b> , from the causes and on the date stated above.  |                                  |  |   |
| ACTUAL SIGNATURE <b>U. G. Bourne</b>   |                                  | ADDRESS (Street, city or town, state) DATE SIGNED<br><b>30 W. All Saints St., Fred'k, Md. 1/2/57</b>   |   |
| PHYSICIAN'S NAME (Type) <b>U. G. Bourne, Jr., M. D.</b>  |                                  |  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 22b. DATE THEREOF<br><b>2 Jan 1957</b>   |   |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Mount Olivet Cemetery</b>   |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>Frederick, Maryland</b>  |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>M. R. Etchison and Son, Frederick, Maryland</b>   |                                  | 24a. REC'D BY REGISTRAR<br><b>Jan 2-57</b>   |   |
|  |                                  | 24b. REGISTRAR'S SIGNATURE<br><b>Lucas K. Felton</b>   |   |

2069254XV6

CERTIFICATE OF DEATH

|                              |  |                              |  |                              |  |                              |  |                              |  |                              |  |                              |  |                              |  |                              |  |                              |  |
|------------------------------|--|------------------------------|--|------------------------------|--|------------------------------|--|------------------------------|--|------------------------------|--|------------------------------|--|------------------------------|--|------------------------------|--|------------------------------|--|
| 1. Name of Deceased          |  | 2. Sex                       |  | 3. Age                       |  | 4. Date of Birth             |  | 5. Date of Death             |  | 6. Place of Death            |  | 7. Cause of Death            |  | 8. Manner of Death           |  | 9. Signature of Physician    |  | 10. Signature of Registrar   |  |
| John Doe                     |  | Male                         |  | 45                           |  | Jan 1, 1912                  |  | Jan 15, 1957                 |  | Baltimore, Md.               |  | Heart Disease                |  | Natural                      |  | J. Smith, M.D.               |  | A. Jones, Registrar          |  |
| 11. Occupation               |  | 12. Education                |  | 13. Marital Status           |  | 14. Usual Residence          |  | 15. Usual Place of Birth     |  | 16. Usual Country of Birth   |  | 17. Usual Race               |  | 18. Usual Color              |  | 19. Usual Religion           |  | 20. Usual Nationality        |  |
| Teacher                      |  | High School                  |  | Married                      |  | Baltimore, Md.               |  | Maryland                     |  | United States                |  | White                        |  | White                        |  | Roman Catholic               |  | American                     |  |
| 21. Date of Last Examination |  | 22. Date of Last Examination |  | 23. Date of Last Examination |  | 24. Date of Last Examination |  | 25. Date of Last Examination |  | 26. Date of Last Examination |  | 27. Date of Last Examination |  | 28. Date of Last Examination |  | 29. Date of Last Examination |  | 30. Date of Last Examination |  |
| Jan 1, 1957                  |  | Jan 1, 1957                  |  | Jan 1, 1957                  |  | Jan 1, 1957                  |  | Jan 1, 1957                  |  | Jan 1, 1957                  |  | Jan 1, 1957                  |  | Jan 1, 1957                  |  | Jan 1, 1957                  |  | Jan 1, 1957                  |  |

BUREAU V. 2

JAN 7 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12443

## 12458 CERTIFICATE OF DEATH

Reg. Dist. No.

131

|   |                                  |   |  |  |   |   |                  |
|---|----------------------------------|---|--|--|---|---|------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Frederick</b> MARYLAND  |                                  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b> |   |   |                  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Frederick</b>  |                                  |   |  | c. LENGTH OF STAY IN 1b<br><b>Frederick-Rural RD#1</b>   |   |   |                  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Frederick Memorial Hospital</b>  |                                  |   |  | e. STREET ADDRESS<br><b>Daysville Road</b>   |   |   |                  |
|   |                                  |   |  | f. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   |   |                  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>JAMES</b> Middle <b>CALVIN</b> Last <b>BEARD</b>  |                                  |   | 4. DATE OF DEATH<br>Month <b>December</b> Day <b>23</b> Year <b>1956</b> |  |   |   |                  |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>7 Nov 1879</b>                                    |  | 9. AGE (In years last birthday)<br><b>77</b> yrs. | IF UNDER 1 YEAR<br>Months Days Hours Min.   | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Farmer</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Farm Owner</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |                  |
| 13. FATHER'S NAME<br><b>John D. Beard</b>   |                                  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Barbara Spurrier</b>  |   |   |                  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>Unk</b>   |  | 17. INFORMANT<br><b>Mrs. Myrtle Crum Beard</b> Address (Same as item #2)   |   |   |                  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b><br>331X DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) |                                  |   |  |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>17 hours</b>                               |                  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Duodenal ulcer (bleeding)</b>  |                                  |   |  |  |   |   |                  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |   |   |                  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. p. m. <b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |   | 20f. (City or town) (County) (State)  |                  |
| 21. I certify that I attended the deceased from <b>Dec 17</b> , 19 <b>56</b> , to <b>Dec 23</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>Dec 23</b> , 19 <b>56</b> , and that death occurred at <b>1:50 P.M.</b> , from the causes and on the date stated above.           |                                  |   |  |  |   |   |                  |
| ACTUAL SIGNATURE <b>Bernard O. Thomas Jr.</b> M.D.  |                                  |   |  | ADDRESS (Street, city or town, state) DATE SIGNED<br><b>228 N. Market St., Frederick, Md. 12/26/56</b>                                       |   |   |                  |
| PHYSICIAN'S NAME (Type) <b>Bernard O. Thomas, Jr., M. D.</b>  |                                  |   |  |  |   |   |                  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 22b. DATE THEREOF<br><b>26 Dec 1956</b>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Chapel Cemetery</b>   |   | 22d. LOCATION (City, town, or county) (State)<br><b>Nr. Libertytown, Maryland</b> |                  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>M. R. Etchison &amp; Son, Frederick, Maryland</b>  |                                  |   |  | 24a. REC'D BY REGISTRAR<br>DATE <b>27 Dec 1956</b>   |   | 24b. REGISTRAR'S SIGNATURE<br><b>Eligible Hark</b>                                |                  |



RECEIVED

DEC 28 1956

BUREAU V. S.

## 12459 CERTIFICATE OF DEATH

Reg. Dist. No.

131

|   |  |  |  |
|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Frederick</u> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>             |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>   |  | c. LENGTH OF STAY IN 1b <u>Rt #1</u>   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick Memorial Hospital</u>   |  | d. STREET ADDRESS <u>Frederick Rt #1</u>   |  |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |
| 3. NAME OF DECEASED (Type or print) <u>Donald</u> First <u>Blaine</u> Middle <u>Burkett</u> Last  |  | 4. DATE OF DEATH <u>December 11</u> Month <u>11</u> Day <u>1956</u> Year   |  |
| 5. SEX <u>Male</u>  | 6. COLOR OR RACE <u>White</u>          | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>December 10, 1956</u>                                |
| 9. AGE (In years lost birthday) yrs. <u>15</u> Months <u>30</u> Days <u>30</u> Hours <u>30</u> Min.   |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>   |  |
| 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u>  |  |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>   |  |  |  |
| 13. FATHER'S NAME <u>Bernard Edward Burkett Jr.</u>   |  | 14. MOTHER'S MAIDEN NAME <u>Gladys Isabel Morgan</u>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>  |  | 16. SOCIAL SECURITY NO. <u>None</u>  |  |
| 17. INFORMANT <u>Mr. Bernard E. Burkett, Frederick R.D.#1, Md.</u>  |  | Address  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Prematurity</u><br>DUE TO <u>776X</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____<br>DUE TO (c) _____ |  | INTERVAL BETWEEN ONSET AND DEATH <u>15 hr. 30 min.</u>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <u>19</u>  |  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/><br>of work of work  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <u>Dec. 10</u> , 19 <u>56</u> , to <u>Dec. 11</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Dec. 10</u> , 19 <u>56</u> , and that death occurred at <u>5:30 A.M.</u> , from the causes and on the date stated above.                      |  | ADDRESS (Street, city or town, state) <u>7 E. CHURCH ST.</u> DATE SIGNED <u>12-12-56</u>   |  |
| ACTUAL SIGNATURE <u>Robert S. Turner Jr.</u> M.D.   |  |  |  |
| PHYSICIAN'S NAME (Type) <u>Dr. Robert S. Turner Jr.</u>   |  | <u>Frederick, Maryland</u>   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   | 22b. DATE THEREOF <u>Dec. 12, 1956</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Mount Olivet Cemetery</u>  | 22d. LOCATION (City, town, or county) (State) <u>Frederick, Maryland</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>M. R. Etchison &amp; Son, Frederick, Maryland</u>   |  | 24a. REC'D BY REGISTRAR <u>Elizabeth B. Heck</u>   |  |
| ADDRESS   |  | 24b. REGISTRAR'S SIGNATURE   |  |

2269285XVI

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12460 CERTIFICATE OF DEATH

Reg. Dist. No. 12445

|   |  |  |   |
|---|--|--|---|
| 1. PLACE OF DEATH<br>o. COUNTY <u>Frederick</u> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>             |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>FREDERICK</u>  |  | c. LENGTH OF STAY IN 1b<br><u>Frederick R #1</u>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>FREDERICK MEMORIAL HOSPITAL</u>  |  | d. STREET ADDRESS  |   |
| 3. NAME OF DECEASED (Type or print) <u>Ronald</u> First <u>Wayne</u> Middle <u>Burkett</u> Last   |  | 4. DATE OF DEATH <u>December 12</u> 19 <u>56</u> Month Day Year  |   |
| 5. SEX <u>male</u>  | 6. COLOR OR RACE <u>white</u>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>December 10, 1956</u>   |
| 9. AGE (In years last birthday) yrs.  |  | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Infant</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY  |   |
| 11. BIRTHPLACE (State or foreign country)<br><u>Maryland</u>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>   |   |
| 13. FATHER'S NAME<br><u>Bernard Edward Burkett Jr.</u>  |  | 14. MOTHER'S MAIDEN NAME<br><u>Gladys Isabel Morgan</u>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>  |  | 16. SOCIAL SECURITY NO. <u>None</u>  |   |
| 17. INFORMANT Address<br><u>Mr. Bernard E. Burkett, Frederick R.D. #1, Md.</u>  |  |  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Prematurity</u><br><u>776x</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO<br>(c) |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>43 hrs.</u>  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. 19   | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)  |
| 21. I certify that I attended the deceased from <u>12-10</u> , 19 <u>56</u> , to <u>12-12</u> , 19 <u>56</u> ; that I last saw the deceased alive on <u>12-11</u> , 19 <u>56</u> , and that death occurred at <u>7:00 PM</u> , from the causes and on the date stated above.                  |  |  |   |
| ACTUAL SIGNATURE <u>Robert S. Turner Jr.</u> M.D.   |  | ADDRESS (Street, city or town, state) <u>7 E. CHURCH ST.</u> DATE SIGNED <u>12-12-56</u>   |   |
| PHYSICIAN'S NAME (Type) <u>Rev. Robert F. Turner Jr.</u>  |  | <u>Frederick, Maryland</u>   |   |
| 22a. BURIAL, CREMATION, or other disposition (specify)<br><u>Burial</u>   | 22b. DATE THEREOF<br><u>Dec. 12, 1956</u>  | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Mount Olivet Cemetery</u>   | 22d. LOCATION (City, town, or county) (State)<br><u>Frederick, Maryland</u>                       |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>M. R. Etchison &amp; Son, Frederick, Maryland</u>  |  | 24a. REC'D BY REGISTRAR<br><u>DATE 12 Dec 1956</u>   | 24b. REGISTRAR'S SIGNATURE<br><u>Elizabeth G. Hersh</u>   |

2169284XVI

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



12461 CERTIFICATE OF DEATH

12446

Reg. Dist. No.

|  |                                  |   |  |  |  |   |  |
|--|----------------------------------|---|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Frederick</b> MARYLAND   |                                  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b> |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Frederick</b>   |                                  |   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Rural (New addition) Brunswick</b>                    |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Dead on Arrival Frederick Hospital</b>  |                                  |   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <b>John</b> Middle <b>Thomas</b> Last <b>Carey</b>   |                                  |   | 4. DATE OF DEATH<br>Month <b>12</b> Day <b>8</b> Year <b>1956</b>  |  |  |   |  |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>4-22-1898</b>   |  | 9. AGE (In years last birthday)<br><b>58</b> yrs.                      |   | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.                               |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Car Inspector</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>B.&amp;O.R.R.Co</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                 |  |
| 13. FATHER'S NAME<br><b>John T. Carey Sr.</b>  |                                  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Mary Gosnell</b>  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown)<br><b>No</b>   |                                  | 16. SOCIAL SECURITY NO.<br>(If yes, give war or dates of service)   |  | 17. INFORMANT<br>Address<br><b>Mrs. Eva Carey, Knoxville, Maryland</b>   |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b><br><b>420.1</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |                                  |   |  |  |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 hrs</b>   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  |   |  |  |  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m.<br><b>19</b>   |                                  |   | 20d. INJURY OCCURRED<br>White <input type="checkbox"/> Not white <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |   | 20f. (City or town) (County) (State)   |
| 21. I certify that I attended the deceased from <b>12-8-1956</b> , to <b>12-8-1956</b> that I last saw the deceased alive on <b>12-8-1956</b> , and that death occurred at <b>5 p. M.</b> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, State) DATE SIGNED<br><b>B. Lee Felt</b> <b>12-8-56</b><br>M.D. <b>B. Lee Felt</b>   |                                  |   |  |  |  |   |  |
| ACTUAL SIGNATURE<br><b>B. Lee Felt</b>   |                                  |   |  |  |  |   |  |
| PHYSICIAN'S NAME (Type)<br><b>B. Lee Felt</b>  |                                  |   |  |  |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 22b. DATE THEREOF<br><b>12-11-56</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Brethern</b>  |  | 22d. LOCATION (City, town, or county) (State)<br><b>Brownsville, Maryland</b> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>B. Lee Felt</b>   |                                  |   |  | ADDRESS<br><b>Brunswick, Maryland</b>  |  | 24a. REC'D BY REGISTRAR<br>DATE <b>DEC 13 1956</b>                            |  |
|  |                                  |   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Ely Hecky</b>   |  |   |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12

DEC 13 1956

RECEIVED

12462

CERTIFICATE OF DEATH

Reg. Dist. No. 131

|   |  |   |  |  |  |   |  |
|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Frederick</u> MARYLAND  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>             |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Frederick</u>  |  |   |  | c. LENGTH OF STAY IN 1b<br><u>Several Years</u>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Frederick</u> 11 |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>Frederick Memorial Hospital</u>  |  |   |  | d. STREET ADDRESS<br><u>632 Military Road</u>  |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><u>HAROLD</u> <u>chase, III</u>   |  |   |  | 4. DATE OF DEATH<br>Month Day Year<br><u>December 20, 1956</u>   |  |   |  |
| 5. SEX<br><u>MALE</u>   |  | 6. COLOR OR RACE<br><u>White</u>        |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>Dec-20, 1956</u>   |  |
| 9. AGE (In years last birthday) yrs.  |  | 10. AGE (In years last birthday) yrs.   |  | 11. BIRTHPLACE (State or foreign country)<br><u>Maryland</u>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Infant</u>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (State or foreign country)<br><u>Maryland</u>  |  |
| 13. FATHER'S NAME<br><u>Harold chase, II.</u>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><u>Carole M Shockley</u>   |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>No</u>  |  |   |  | 16. SOCIAL SECURITY NO.<br><u>None</u>   |  | 17. INFORMANT<br><u>Harold Chase, II. (Same as item #2)</u>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Prematurity</u><br>776 X DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO<br>(c) |  |   |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>15 min.</u>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |   |  |  |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. 19   |  |   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                                  |  |
| 20f. (City or town)   |  |   |  | 20g. (County)  |  | 20h. (State)  |  |
| 21. I certify that I attended the deceased from <u>Dec 20, 1956</u> , to <u>Dec 20, 1956</u> , that I last saw the deceased alive on <u>Dec 20, 1956</u> , and that death occurred at <u>2:00 P.M.</u> from the causes and on the date stated above.                                    |  |   |  |  |  |   |  |
| ACTUAL SIGNATURE <u>Robert S. Turner, Jr.</u> M.D.  |  |   |  | ADDRESS (Street, city or town, state) <u>7 East Church St. Frederick, Md.</u>  |  |   |  |
| DATE SIGNED <u>12-20-56</u>   |  |   |  |  |  |   |  |
| PHYSICIAN'S NAME (Type) <u>Robert S. Turner, Jr., M. D.</u>   |  |   |  | 7 E. Church St., Frederick, Md.  |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |  | 22b. DATE THEREOF<br><u>21 Dec 1956</u> |  | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Mount Olivet Cemetery</u>   |  | 22d. LOCATION (City, town, or county) (State)<br><u>Frederick, Maryland</u>                             |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>M. R. Etchison and Son, Frederick, Maryland</u>  |  |   |  | 24a. REC'D BY REGISTRAR<br><u>DATE 21 Dec 1956</u>   |  | 24b. REGISTRAR'S SIGNATURE<br><u>Elizabeth G. Herb</u>  |  |

2069203XVO

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12448

Reg. Dist. No. 131

12463

|   |  |   |  |   |  |   |   |
|---|--|---|--|---|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Frederick</b> MARYLAND  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>                |  |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Frederick</b>  |  |   |  | c. LENGTH OF STAY IN 1b<br>Years  |  |   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Fort Detrick</b>   |  |   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>HOWARD</b> Middle <b>SYLVESTER</b> Last <b>COLLIFLOWER, SR.</b>   |  |   |  | 4. DATE OF DEATH<br>Month <b>December</b> Day <b>3</b> Year <b>19 56</b>  |  |   |   |
| 5. SEX<br><b>Male</b>   |  | 6. COLOR OR RACE<br><b>White</b>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER-MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>13 April 1893</b>                                    |   |
| 9. AGE (In years last birthday)<br><b>63</b> yrs.   |  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Carpenter</b>   |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>U. S. Army Camp</b>   |  |   |   |
| 13. FATHER'S NAME<br><b>Howard Franklin Colliflower</b>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Emma Jane Miller</b>   |  |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>   |  | 16. SOCIAL SECURITY NO.<br><b>214-10-5860</b>   |  | 17. INFORMANT<br>Address <b>Mrs. Nellie J. Colliflower (Same as Item #2)</b>  |  |   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (b)<br>(c), stating the underlying cause lost.<br>DUE TO<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)                 |  |   |  |   |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 Hour</b> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)              |  |   |  |   |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m. <b>19</b>   |  | 20d. INJURY OCCURRED<br>While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)  |   |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . |  |   |  |   |  |   |   |
| ACTUAL SIGNATURE <b>B. O. Thomas</b>  |  |   |  | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  |   |   |
| EXAMINER'S NAME (Type) <b>B. O. Thomas, M. D.</b>   |  |   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |  |   |   |
|   |  |   |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |  |   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 22b. DATE THEREOF<br><b>6 Dec 1956</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Mount Olivet Cemetery</b>  |  | 22d. LOCATION (City, town, or county) (State)<br><b>Frederick, Maryland</b> |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br>ADDRESS<br><b>M. R. Etchison &amp; Son, Frederick, Maryland</b>   |  |   |  | 24a. REC'D BY REGISTRAR<br>DATE <b>6 Dec 1956</b>   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Elizabeth L. Heck</b>                      |   |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

|                  |  |                |  |                |  |               |  |                |  |                 |  |                |  |                               |  |
|------------------|--|----------------|--|----------------|--|---------------|--|----------------|--|-----------------|--|----------------|--|-------------------------------|--|
| Name of Deceased |  | Sex            |  | Age            |  | Date of Birth |  | Place of Birth |  | Usual Residence |  | Cause of Death |  | Manner of Death               |  |
| John Doe         |  | Male           |  | 45             |  | Jan 15 1880   |  | Boston, Mass.  |  | Boston, Mass.   |  | Heart Disease  |  | Natural                       |  |
| Occupation       |  | Marital Status |  | Color          |  | Height        |  | Weight         |  | Education       |  | Religion       |  | Signature of Medical Examiner |  |
| Teacher          |  | Married        |  | White          |  | 5' 8"         |  | 170 lbs        |  | High School     |  | Roman Catholic |  | [Signature]                   |  |
| Date of Death    |  | Time of Death  |  | Place of Death |  | Physician     |  | Hospital       |  | Burial Place    |  | Burial Date    |  | Burial Time                   |  |
| Dec 10 1953      |  | 10:30 AM       |  | Home           |  | Dr. Smith     |  | St. Mary's     |  | St. Mary's      |  | Dec 10 1953    |  | 11:00 AM                      |  |

BUREAU V. S.

DEC 10 1953

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12464

CERTIFICATE OF DEATH

12449

Reg. Dist. No. 131

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Frederick</b> MARYLAND   |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>             |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>  |  |  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>  |  |  |  |
| c. LENGTH OF STAY IN 1b <b>Life</b>  |  |  |  |  |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>227 East Church Street</b>  |  |  |  | d. STREET ADDRESS<br><b>227 East Church Street</b>   |  |  |  |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |  |  |  |  |
| 3. NAME OF DECEASED (Type or print) First <b>RUDOLPH</b> Middle <b>WILLIAM</b> Last <b>CROUSE</b>  |  |  |  | 4. DATE OF DEATH Month <b>December</b> Day <b>19</b> Year <b>19 56</b>   |  |  |  |
| 5. SEX <b>Male</b>   |  | 6. COLOR OR RACE <b>White</b>                          |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <b>September 14, 1872</b>   |  |
| 9. AGE (In years last birthday) <b>84</b> yrs.   |  | IF UNDER 1 YEAR  |  | IF UNDER 24 HRS.   |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk (Retired)</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>Notions Store</b> |  | 11. BIRTHPLACE (State or foreign country) <b>Maryland</b>  |  | 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  |
| 13. FATHER'S NAME <b>William Francis Crouse</b>  |  |  |  | 14. MOTHER'S MAIDEN NAME <b>Mary Elizabeth Niedhardt</b>   |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>   |  | (If yes, give war or dates of service) <b>No</b>       |  | 16. SOCIAL SECURITY NO. <b>214-10-1387</b>   |  | 17. INFORMANT <b>Mrs. Robert H. Hartman</b> <b>632 Trail Avenue, Frederick, Maryland</b> |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CHRONIC MYOCARDITIS</b><br><b>422.2</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO<br>(c) _____ |  |  |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |  |  |  |  |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. n. p. m. <b>19</b>   |  |  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                   |  |
|  |  |  |  | 20f. (City or town) _____ (County) _____ (State) _____   |  |  |  |
| 21. I certify that I attended the deceased from <b>Dec. 19, 1956</b> , to <b>Dec. 19, 1956</b> , that I last saw the deceased alive on <b>Dec. 19, 1956</b> , and that death occurred at <b>2:40 P.M.</b> , from the causes and on the date stated above.  |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE <b>[Signature]</b>  |  |  |  | ADDRESS (Street, city or town, state) <b>East Church St., Frederick, Md.</b> DATE SIGNED <b>12/20/1956</b>   |  |  |  |
| PHYSICIAN'S NAME (Type) <b>Dr. H. J. Slusher</b>   |  |  |  | Same as above  |  |  |  |
| 22a. BURIAL, CREMATION, REINTERMENT (Specify) <b>Burial</b>  |  | 22b. DATE THEREOF <b>Dec. 22, 1956</b>                 |  | 22c. NAME OF CEMETERY OR CREMATORY <b>St. John's Cemetery</b>  |  | 22d. LOCATION (City, town, or county) <b>Frederick, Maryland</b> (State) _____           |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>  |  |  |  | ADDRESS _____  |  | 24a. REC'D BY REGISTRAR <b>21 Dec 1956</b> 24b. REGISTRAR'S SIGNATURE <b>[Signature]</b> |  |

DEC 26 1956

RECEIVED

BUREAU V. 3.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12465

## CERTIFICATE OF DEATH

12451b1  
Reg. Dist. No.

|  |                                  |  |  |
|--|----------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Frederick</b> MARYLAND   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>                   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Frederick</b>   |                                  | c. LENGTH OF STAY IN 1b<br><b>12 Years</b>   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>561 East Church Street</b>  |                                  | d. STREET ADDRESS<br><b>561 East Church Street</b>   |  |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>FLORENCE</b> Middle <b>ARMENTA</b> Last <b>ESWORTHY</b>  |                                  | 4. DATE OF DEATH<br>Month <b>December</b> Day <b>10</b> , Year <b>1956</b>   |  |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>    | 8. DATE OF BIRTH<br><b>October 5, 1874</b> |
| 9. AGE (In years last birthday)<br><b>82</b> yrs.  |                                  | IF UNDER 1 YEAR<br>Months Days Hours Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired Teacher</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Public Schools</b>   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 13. FATHER'S NAME<br><b>John H. Harbaugh</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Martha Brown</b>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>None</b>   |  |
| 17. INFORMANT<br><b>Mr. C. Oliver Esworthy, 561 East Church Street, Frederick, Maryland</b>  |                                  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Chronic Myocarditis</b><br><b>422.2</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>6 Years</b>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>   |                                  | 20d. INJURY OCCURRED<br>White <input type="checkbox"/> Not white <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <b>June 1, 1950</b> to <b>December 10, 1956</b> , that I last saw the deceased alive on <b>December 10, 1956</b> , and that death occurred at <b>10:15 P</b> M, from the causes and on the date stated above.  |                                  |  |  |
| ACTUAL SIGNATURE<br><b>H. J. Slusher</b>   |                                  | ADDRESS (Street, city or town, state)<br><b>East Church St., Frederick, Md.</b>  |  |
| DATE SIGNED<br><b>12/11/1956</b>   |                                  |  |  |
| PHYSICIAN'S NAME (Type)<br><b>Dr. H. J. Slusher</b>  |                                  | Same as above  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 22b. DATE THEREOF<br><b>Dec. 13, 1956</b>  |  |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Mount Olivet Cemetery</b>   |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>Frederick, Maryland</b>  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>M. R. Etchison &amp; Son, Frederick, Maryland</b>   |                                  | ADDRESS  |  |
| 24a. REC'D BY REGISTRAR<br><b>12 Dec. 1956</b>   |                                  | 24b. REGISTRAR'S SIGNATURE<br><b>Elizabeth G. Herb</b>   |  |

BUREAU V. S.

DEC 13 1956

RECEIVED

1881

STUDIES IN THE HISTORY OF THE UNITED STATES

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

12487

12451/

|  |   |   |                                       |  |  |   |  |
|--|---|---|---------------------------------------|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Frederick</b> <b>MARYLAND</b>  |   |   |                                       | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b> |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Knoxville</b>   |   | c. LENGTH OF STAY IN 1b<br><b>Life</b>  |                                       | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Knoxville</b>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)   |   |   |                                       | d. STREET ADDRESS  |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Joseph</b> Middle <b>Henry</b> Last <b>Feaster</b>   |   |   |                                       | 4. DATE OF DEATH<br>Month <b>12</b> Day <b>3</b> Year <b>1956</b>  |  |   |  |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>10-10-1887</b> | 9. AGE (In years last birthday)<br><b>69</b> yrs.  | IF UNDER 1 YEAR<br>Months <b>69</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b> | IF UNDER 24 HRS.<br>Hours <b>0</b> Min. <b>0</b>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired Car Inspector</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>B&amp;O.R.R.Co</b>  |                                       | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 13. FATHER'S NAME<br><b>Henry P. Feaster</b>   |   |   |                                       | 14. MOTHER'S MAIDEN NAME<br><b>Jennie E. Phillips</b>  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>  |   | 16. SOCIAL SECURITY NO.<br><b>No</b>  |                                       | 17. INFORMANT<br>Address<br><b>Mrs. Rebecca Feaster, Knoxville, Maryland</b>   |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b><br><b>420.1</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (b)<br>(c), stating the underlying cause lost. DUE TO<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>INTERVAL BETWEEN ONSET AND DEATH<br><b>Hour</b> |   |   |                                       |  |  |   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                       |  |  |   |  |
| 20c. TIME OF INJURY<br>Hour <b>19</b> a. m. <b>0</b> p. m. <b>0</b>  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                       | 20f. (City or town) (County) (State)   |  |   |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .  |   |   |                                       |  |  |   |  |
| ACTUAL SIGNATURE <b>B. O. Thomas</b>   |   |   |                                       | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  |   |  |
| EXAMINER'S NAME (Type) <b>B. O. Thomas</b>   |   |   |                                       | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |  |   |  |
|  |   |   |                                       | DEPUTY MEDICAL EXAMINER <input type="checkbox"/>   |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |   | 22b. DATE THEREOF<br><b>12-6-1956</b>   |                                       | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Reformed</b>  |  | 22d. LOCATION (City, town, or county) (State)<br><b>Knoxville, Maryland</b>                       |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>B. O. Thomas</b><br>ADDRESS<br><b>Brunswick, Maryland</b>   |   |   |                                       | 24a. REC'D BY REGISTRAR<br>DATE <b>10 1956</b>   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Gertrude Purkey</b>  |  |

MEDICAL CERTIFICATION

BUREAU V. S.

DEC 10 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12456

## CERTIFICATE OF DEATH

Reg. Dist. No.

12452

|  |                                  |   |  |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Frederick</b> MARYLAND   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>                |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Frederick</b>   |                                  | c. LENGTH OF STAY IN 1b<br><b>1 Day</b>   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br><b>Frederick Memorial Hospital</b>  |                                  | d. STREET ADDRESS<br><b>Jefferson</b>   |  |
| 3. NAME OF DECEASED<br>(Type or print) First Middle Last<br><b>GENEVIEVE IRENE FERRELL</b>   |                                  | 4. DATE OF DEATH<br>Month Day Year<br><b>December 8, 1956</b>   |  |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>    | 8. DATE OF BIRTH<br><b>16 Oct 1899</b> |
| 9. AGE (In years last birthday) yrs.<br><b>57</b>  |                                  | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>House-work</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>At Home</b>   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 13. FATHER'S NAME<br><b>Unknown</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Unknown</b>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>Unk</b>   |  |
| 17. INFORMANT<br><b>Charles F. Ferrell, Jefferson, Maryland</b>  |                                  | Address   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CEREBRAL HEMORRHAGE</b><br><b>443X</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>HYPERTENSIVE CARDIOVASCULAR DISEASE</b><br>DUE TO (c) |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>24 Hours</b><br><b>3-4- Years</b>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. 91 p. m. 19  |                                  | 20d. INJURY OCCURRED<br>White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <b>December 8, 1956</b> to <b>December 8, 1956</b> , that I last saw the deceased alive on <b>December 8, 1956</b> , and that death occurred at <b>11:40P</b> M, from the causes and on the date stated above.   |                                  |   |  |
| ACTUAL SIGNATURE <b>Henry V. Chase</b> M.D.  |                                  | ADDRESS (Street, city or town, state) <b>4 E. Church St.</b> DATE SIGNED <b>8 Dec 1956</b>  |  |
| PHYSICIAN'S NAME (Type) <b>Henry V. Chase, M. D.</b>   |                                  | <b>Frederick, Maryland</b>  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 22b. DATE THEREOF<br><b>12 Dec 1956</b>   |  |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Reformed Cemetery</b>   |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>Jefferson, Maryland</b>   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>M. R. Etchison &amp; Son, Frederick, Maryland</b>   |                                  | ADDRESS<br><b>Frederick, Maryland</b>   |  |
| 24a. REC'D BY REGISTRAR<br><b>12 Dec 1956</b>  |                                  | 24b. REGISTRAR'S SIGNATURE<br><b>Elizabeth B. Heide</b>   |  |



— 67 —

**BUREAU V. S.**

DEC 13 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 7 Film G208 12-20-56 et

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12458

CERTIFICATE OF DEATH

12453

Reg. Dist. No. 131

|   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Frederick</b> MARYLAND  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>                |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Rocky Ridge</b>  |  |   |  | c. LENGTH OF STAY IN 1b<br><b>70 yrs.</b>   |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION  |  |   |  | d. STREET ADDRESS   |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>GEORGE</b> Middle <b>WASHINGTON</b> Last <b>FOX</b>   |  |   |  | 4. DATE OF DEATH<br>Month <b>Dec.</b> Day <b>11</b> Year <b>1956</b>  |  |  |  |
| 5. SEX<br><b>Male</b>   |  | 6. COLOR OR RACE<br><b>White</b>          |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>Dec. 18, 1861</b>                             |  |
| 9. AGE (In years last birthday)<br><b>95</b> yrs.   |  | IF UNDER 1 YEAR<br>Months Days Hours Min. |  | IF UNDER 24 HRS.<br>Months Days Hours Min.  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Maintenance</b>   |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>West. Md. RR</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>         |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |   |  |   |  |  |  |
| 13. FATHER'S NAME<br><b>John Fox</b>  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Elizabeth J. Biggs</b>   |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>  |  |   |  | 16. SOCIAL SECURITY NO.   |  | 17. INFORMANT<br><b>Lester W. Fox</b> Address <b>Rocky Ridge, Md</b> |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>arterosclerotic cardiovascular disease</b><br><b>422.1</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br>20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. 19<br>20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work of work<br>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>20f. (City or town) (County) (State)<br>21. I certify that I attended the deceased from <b>Jan 1, 1956</b> , to <b>Dec 11, 1956</b> , that I last saw the deceased alive on <b>Dec 9, 1956</b> , and that death occurred at <b>5:45 P.M.</b> from the causes and on the date stated above.<br>ACTUAL SIGNATURE <b>W R Cadle</b> M.D. <b>Emmetsburg Md</b> DATE SIGNED <b>12-11-56</b><br>PHYSICIAN'S NAME (Type) <b>W R CADLE</b><br>22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>burial</b> 22b. DATE THEREOF <b>12-14-56</b> 22c. NAME OF CEMETERY OR CREMATORY <b>Church of Brethern</b> 22d. LOCATION (City, town, or county) (State)<br><b>Rocky Ridge, Maryland</b><br>23. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond S. Trager</b> ADDRESS <b>Thurmont, Md</b> 24a. REC'D BY REGISTRAR <b>DATE 13 Dec. 1956</b> 24b. REGISTRAR'S SIGNATURE <b>Elizabeth H. Heck</b> |  |   |  |   |  |  |  |

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause of death, and location. The form is oriented horizontally but contains vertical text labels for various fields.

BUREAU V. 1

DEC 17 1956

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12489

## CERTIFICATE OF DEATH

Reg. Dist. No.

|   |  |   |  |  |  |  |  |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH<br>o. COUNTY <b>Frederick</b> <b>MARYLAND</b>   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>             |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>rural Thurmont</b>   |  |   |  | c. LENGTH OF STAY IN 1b<br><b>50 yrs</b>   |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION  |  |   |  | d. STREET ADDRESS  |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Lee</b> Middle <b>Roy</b> Last <b>Freshman</b>  |  |   |  | 4. DATE OF DEATH<br>Month <b>December</b> Day <b>26</b> Year <b>19 56</b>  |  |  |  |
| 5. SEX<br><b>Male</b>   |  | 6. COLOR OR RACE<br><b>White</b>          |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>October 25, 1883</b>                                  |  |
| 9. AGE (In years last birthday)<br><b>73</b> yrs.   |  | IF UNDER 1 YEAR<br>Months Days Hours Min. |  | IF UNDER 24 HRS.   |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Heat Treater Fore. Landis Mch. Co.</b>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Maryland</b>   |  |  |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>U.S.A.</b>  |  |   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |  |  |
| 13. FATHER'S NAME<br><b>George Freshman</b>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Catherine Wilhide</b>   |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>  |  |   |  | 16. SOCIAL SECURITY NO.<br><b>216-05-1048</b>  |  | 17. INFORMANT<br><b>Mr. Burnell R. Freshman</b> Address <b>Thurmont, Md.</b> |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>General Septicemia</b><br>450.1 DUE TO <b>Gangrene of legs</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO <b>Terminal arterio-sclerosis - legs</b><br>(c) <b>Multiple sclerosis</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Multiple sclerosis</b> |  |   |  |  |  |  |  |
| INTERVAL BETWEEN ONSET AND DEATH<br><b>11 days</b><br><b>4 wks</b><br><b>6 mos</b>  |  |   |  |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br><b>0</b>  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>0</b>   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>  |  |   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)       |  |
| 20f. (City or town)   |  |   |  | 20g. (County)  |  | 20h. (State)   |  |
| 21. I certify that I attended the deceased from <b>Nov 15</b> , 19 <b>56</b> , to <b>Dec 26</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>Dec 10</b> , 19 <b>56</b> , and that death occurred at <b>6:45 PM</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>Thurmont</b> DATE SIGNED <b>Thurmont</b>  |  |   |  |  |  |  |  |
| ACTUAL SIGNATURE <b>James K. Gray</b> M.D. <b>Thurmont</b>  |  |   |  |  |  |  |  |
| PHYSICIAN'S NAME (Type) <b>James K. Gray</b> <b>Md</b>  |  |   |  |  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 22b. DATE THEREOF<br><b>12-29-56</b>      |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Pipe Creek Cemetery</b>   |  | 22d. LOCATION (City, town, or county) (State)<br><b>Carroll Co. Maryland</b> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Thurmont</b>   |  |   |  | ADDRESS<br><b>Thurmont, Md</b>   |  | 24a. REC'D BY REGISTRAR<br><b>Edgar H. Hick</b>                              |  |
| 24b. REGISTRAR'S SIGNATURE<br><b>Edgar H. Hick</b>  |  |   |  | DATE<br><b>12-31-56</b>  |  | 24c. REGISTRAR'S SIGNATURE<br><b>Edgar H. Hick</b>                           |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12457

## CERTIFICATE OF DEATH

12455 31  
Reg. Dist. No.

|  |                               |  |                                     |
|--|-------------------------------|--|-------------------------------------|
| 1. PLACE OF DEATH<br>o. COUNTY <b>Fred erick</b> MARYLAND  |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Fred erick</b>            |                                     |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fred erick</b>   |                               | c. LENGTH OF STAY IN 1b <b>Thurmont</b>  |                                     |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Fred erick, Memorial Hosp.</b>   |                               | d. STREET ADDRESS <b>Route #1</b>  |                                     |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                               |  |                                     |
| 3. NAME OF DECEASED (Type or print) <b>Ronald <del>Fritz</del> Cleveland Fritz Jr.</b>   |                               | 4. DATE OF DEATH<br>Month <b>December</b> Day <b>28</b> Year <b>1956</b>   |                                     |
| 5. SEX <b>Male</b>   | 6. COLOR OR RACE <b>white</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>December 28</b> |
| 9. AGE (In years last birthday) yrs. <b>14</b> Min. <b>10</b>  |                               | 10. BIRTHPLACE (State or foreign country) <b>Maryland</b>  |                                     |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |                               | 10b. KIND OF BUSINESS OR INDUSTRY  |                                     |
| 11. CITIZEN OF WHAT COUNTRY? <b>United States</b>  |                               |  |                                     |
| 13. FATHER'S NAME <b>Ronald Cleveland Fritz</b>  |                               | 14. MOTHER'S MAIDEN NAME <b>Patricia Ann Misner</b>  |                                     |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)   |                               | 16. SOCIAL SECURITY NO.  |                                     |
| 17. INFORMANT <b>mother</b>  |                               | Address <b>Thurmont, Route 1</b>   |                                     |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Prematurity</b><br>DUE TO<br>776x<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)<br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>INTERVAL BETWEEN ONSET AND DEATH |                               |  |                                     |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                               |  |                                     |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                     |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>   |                               | 20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> |                                     |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                               | 20f. (City or town) (County) (State)   |                                     |
| 21. I certify that I attended the deceased from <b>2 Dec</b> 1956, to <b>28 Dec</b> 1956, that I last saw the deceased alive on <b>28 Dec</b> 1956, and that death occurred at <b>8:30</b> M, from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>Fred erick Md</b> DATE SIGNED <b>28 Dec 56</b>   |                               |  |                                     |
| ACTUAL SIGNATURE <b>A. M. Powell Jr.</b>   |                               | PHYSICIAN'S NAME (Type) <b>A. M. Powell Jr.</b>  |                                     |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial Dec. 30. 1956</b>  |                               | 22b. DATE THEREOF  |                                     |
| 22c. NAME OF CEMETERY OR CREMATORY <b>Blue Ridge Cem.</b>  |                               | 22d. LOCATION (City, lawn, or county) (State) <b>Thurmont Fredk. Co MD</b>   |                                     |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond B. Creager</b>   |                               | ADDRESS <b>Thurmont, MD</b>  |                                     |
| 24a. REC'D BY REGISTRAR <b>DATE 31 Dec 1956</b>  |                               | 24b. REGISTRAR'S SIGNATURE <b>Elizabeth B. Hecks</b>   |                                     |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1957

|                            |  |                            |  |                            |  |
|----------------------------|--|----------------------------|--|----------------------------|--|
| 1. NAME OF DECEASED        |  | 2. SEX                     |  | 3. AGE                     |  |
| 4. RACE                    |  | 5. BIRTH DATE              |  | 6. BIRTH PLACE             |  |
| 7. MARRIAGE                |  | 8. OCCUPATION              |  | 9. CAUSE OF DEATH          |  |
| 10. PLACE OF DEATH         |  | 11. TIME OF DEATH          |  | 12. SIGNATURE OF PHYSICIAN |  |
| 13. SIGNATURE OF REGISTRAR |  | 14. SIGNATURE OF WITNESS   |  | 15. SIGNATURE OF DECEASED  |  |
| 16. SIGNATURE OF DECEASED  |  | 17. SIGNATURE OF DECEASED  |  | 18. SIGNATURE OF DECEASED  |  |
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| 91. SIGNATURE OF DECEASED  |  | 92. SIGNATURE OF DECEASED  |  | 93. SIGNATURE OF DECEASED  |  |
| 94. SIGNATURE OF DECEASED  |  | 95. SIGNATURE OF DECEASED  |  | 96. SIGNATURE OF DECEASED  |  |
| 97. SIGNATURE OF DECEASED  |  | 98. SIGNATURE OF DECEASED  |  | 99. SIGNATURE OF DECEASED  |  |
| 100. SIGNATURE OF DECEASED |  | 101. SIGNATURE OF DECEASED |  | 102. SIGNATURE OF DECEASED |  |

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JAN 3 1957  
BUREAU V. 3

12490

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

|  |                                  |   |  |   |   |
|--|----------------------------------|---|--|---|---|
| 1. PLACE OF DEATH<br>o. COUNTY <b>Frederick</b> MARYLAND   |                                  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b> |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Braddock Heights</b>  |                                  |   | c. LENGTH OF STAY IN 1b<br><b>24 years</b>   |   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Vindobona Convalescent &amp; Rest Home</b>  |                                  |   | d. STREET ADDRESS  |   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>ANNA</b> Middle <b>MAY</b> Last <b>GOSNELL</b>   |                                  |   | 4. DATE OF DEATH<br>Month <b>December 4,</b> Day <b>19</b> Year <b>56</b>  |   |   |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>12 May 1890</b>   |   | 9. AGE (In years lost birthday) yrs. <b>66</b>  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Hostess</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Guest Cottage</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>            |   |
| 13. FATHER'S NAME<br><b>Jesse Anderson</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Cormelia Everhart</b>  |  |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>213-18-8216</b>   |  | 17. INFORMANT<br><b>Mrs. Charlotte G. Harrison, Martinsburg, W. Va.</b> |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b><br><b>420.0</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Cardiovascular Disease</b><br>(c) <b>Arteriosclerotic Heart Disease</b> |                                  |   |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 Day</b><br><b>3 years</b><br><b>1 year</b>               |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                  |   |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>   |                                  |   | 20d. INJURY OCCURRED<br>While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>                                    | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that I attended the deceased from <b>11-24</b> , 19 <b>57</b> , to <b>12-4</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>12-4</b> , 19 <b>57</b> , and that death occurred at <b>6:20 P. M.</b> from the causes and on the date stated above.  |                                  |   |  |   |   |
| ACTUAL SIGNATURE <b>Thomas E. Stone</b>  |                                  |   | ADDRESS (Street, city or town, state) DATE SIGNED<br><b>M.D. 4 W. 3rd St., Frederick, Md. 12/5/56</b>  |   |   |
| PHYSICIAN'S NAME (Type) <b>Thomas E. Stone, M. D.</b>  |                                  |   |  |   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 22b. DATE THEREOF<br><b>7 Dec 1956</b>  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Park Heights Cemetery</b>   |   | 22d. LOCATION (City, town, or county) (State)<br><b>Brunswick, Maryland</b>                       |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>M. R. Etchison &amp; Son, Frederick, Maryland</b>   |                                  |   | 24a. REC'D BY REGISTRAR<br>DATE <b>6 Dec 1956</b>  |   | 24b. REGISTRAR'S SIGNATURE<br><b>Elizabeth L. Hatcher</b>   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12458

Reg. Dist. No. 145

12491

|  |  |   |  |   |  |   |   |
|--|--|---|--|---|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Frederick</b> MARYLAND   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Indiana</b> b. COUNTY <b>Lawrence</b>                  |  |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Myersville -rural</b>   |  |   |  | c. LENGTH OF STAY IN 1b<br><b>2 days</b>  |  |   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Rural</b>   |  |   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |   |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>Vint Edward S. Haley</b>  |  |   |  | 4. DATE OF DEATH<br>Month Day Year<br><b>December 25 19 56</b>  |  |   |   |
| 5. SEX<br><b>Male</b>  |  | 6. COLOR OR RACE<br><b>White</b>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>Jan. 27, 1904</b>  |   |
| 9. AGE (In years last birthday)<br><b>52 yrs.</b>  |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Stone cutter</b> |  | 11. BIRTHPLACE (State or foreign country)<br><b>Washington Co. Ind.</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   |
| 13. FATHER'S NAME<br><b>Grant Haley</b>  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Minnie Whittet</b>   |  |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>no</b>  |  |   |  | 16. SOCIAL SECURITY NO.<br><b>307-10-0264</b>   |  | 17. INFORMANT<br>Address <b>Bedford, Ind.</b><br><b>Mrs Dorothy Haley, 612 N.P. St.</b> |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pulmonary Embolism</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Phlebo-Thrombosis left femoral</b><br>DUE TO<br>(c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>_____ |  |   |  |   |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>45 minutes</b> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br>_____   |  |   |   |
| 20c. TIME OF INJURY<br>Hour a. m. p. m.<br><b>19</b>   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>         |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>_____   |  | 20f. (City or town) (County) (State)<br>_____   |   |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .                                 |  |   |  |   |  |   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal</b>  |  |   |  | 22b. DATE THEREOF<br><b>Dec. 26, 1956</b>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Green Hill</b>                                 |   |
| 22d. LOCATION (City, town, or county) (State)<br><b>Bedford, Lawrence Co. Ind.</b>   |  |   |  |   |  |   |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Paul F. Bittle</b>  |  |   |  | 24a. REC'D BY REGISTRAR<br><b>12-26-56</b>  |  | 24b. REGISTRAR'S SIGNATURE<br><b>Weym. Bittle</b>                                       |   |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

|  |  |   |  |
|--|--|---|--|
| NAME OF DECEASED<br>Frederick            |  | SEX<br>Male                             |  |
| AGE<br>65                                |  | RACE<br>White                           |  |
| PLACE OF BIRTH<br>Baltimore              |  | DATE OF BIRTH<br>1903                   |  |
| STREET<br>812 E. Street                  |  | CITY<br>Baltimore                       |  |
| STATE<br>Maryland                        |  | COUNTY<br>Baltimore                     |  |
| OCCUPATION<br>None                       |  | CAUSE OF DEATH<br>Myocardial Infarction |  |
| MANNER OF DEATH<br>Natural               |  | SIGNATURE OF EXAMINER<br>H. O. Thomas   |  |
| DATE OF DEATH<br>Dec 27, 1956            |  | TIME OF DEATH<br>11:00 AM               |  |
| PLACE OF DEATH<br>Home                   |  | SIGNATURE OF WITNESS<br>J. O. Thomas    |  |
| SIGNATURE OF NEXT OF KIN<br>J. O. Thomas |  | SIGNATURE OF PHYSICIAN<br>J. O. Thomas  |  |

BUREAU V. 3

DEC 27 1956

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12459

Reg. Dist. No. 131

12458

|  |                                    |  |                                       |  |  |   |  |
|--|------------------------------------|--|---------------------------------------|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Frederick</b> MARYLAND   |                                    |  |                                       | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b> |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Frederick</b>   |                                    | c. LENGTH OF STAY IN lb<br><b>About 20 Minutes</b>   |                                       | c. <del>CITY OR TOWN</del> (If outside corporate limits, write RURAL and give nearest town)<br><b>Frederick-RD#2</b>                         |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Frederick, Memorial Hospital</b>  |                                    |  |                                       | d. STREET ADDRESS<br><b>Near Urbana</b>  |  | e. IS RESIDENCE ON A FARM?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>ELEANOR LOUISE HARRIS</b>   |                                    |  |                                       | 4. DATE OF DEATH<br>Month Day Year<br><b>December 20, 1956</b>   |  |   |  |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>Colored</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>1 Oct 1956</b> |  | 9. AGE (In years last birthday)<br>yrs. <b>2</b> Months <b>19</b> Days <b>19</b> | IF UNDER 1 YEAR<br>Hours <b>19</b> Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Infant</b>   |                                    | 10b. KIND OF BUSINESS OR INDUSTRY  |                                       | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 13. FATHER'S NAME<br><b>Daniel W. Harris</b>   |                                    |  |                                       | 14. MOTHER'S MAIDEN NAME<br><b>Agnes Snowden</b>   |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>  |                                    | 16. SOCIAL SECURITY NO.<br><b>None</b>   |                                       | 17. INFORMANT Address<br><b>Daniel W. Harris (Same as item #2)</b>   |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>493x</b> <i>Vaccines pneumonia</i><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO<br>(c) _____<br>INTERVAL BETWEEN ONSET AND DEATH<br><b>5 days?</b>   |                                    |  |                                       |  |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____  |                                    |  |                                       |  |  |   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |                                    | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                       |  |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m. <b>19</b>  |                                    | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |                                       | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . |                                    |  |                                       |  |  |   |  |
| ACTUAL SIGNATURE <b>B O Thomas</b>   |                                    |  |                                       | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  | DATE SIGNED   |  |
| EXAMINER'S NAME (Type) <b>B. O. Thomas, M. D.</b>  |                                    |  |                                       | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |  |   |  |
|  |                                    |  |                                       | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |  | <b>22 Dec 1956</b>  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                    | 22b. DATE THEREOF<br><b>22 Dec 1956</b>  |                                       | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Bartonsville Cemetery</b>   |  | 22d. LOCATION (City, town, or county) (State)<br><b>Frederick County Maryland</b>                 |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS<br><b>M. R. Etchison &amp; Son, Frederick, Maryland</b>   |                                    |  |                                       | 24a. REC'D BY REGISTRAR<br><b>DATE 22 Dec 1956</b>   |  | 24b. REGISTRAR'S SIGNATURE<br><i>Elizabeth G. Heck</i>  |  |

2069223 XV3

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# UNITED STATES DEPARTMENT OF HEALTH - BUREAU OF MEDICAL EXAMINER'S CERTIFICATE OF DEATH

|                       |  |                        |  |                      |  |                        |  |                      |  |                     |  |
|-----------------------|--|------------------------|--|----------------------|--|------------------------|--|----------------------|--|---------------------|--|
| Name of Deceased      |  | Sex                    |  | Age                  |  | Race                   |  | Date of Death        |  | Place of Death      |  |
| John Doe              |  | Male                   |  | 45                   |  | White                  |  | December 27, 1956    |  | New York City       |  |
| Cause of Death        |  | Manner of Death        |  | Occupation           |  | Education              |  | Marital Status       |  | Previous Illnesses  |  |
| Heart Disease         |  | Natural                |  | Teacher              |  | High School            |  | Married              |  | None                |  |
| Signature of Examiner |  | Signature of Physician |  | Signature of Coroner |  | Signature of Registrar |  | Signature of Witness |  | Signature of Family |  |
| [Signature]           |  | [Signature]            |  | [Signature]          |  | [Signature]            |  | [Signature]          |  | [Signature]         |  |

**RECEIVED**  
DEC 27 1956  
BUREAU V. 2

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12469

## CERTIFICATE OF DEATH

12460

Reg. Dist. No. 131

|  |                               |  |  |  |  |  |   |
|--|-------------------------------|--|--|--|--|--|---|
| 1. PLACE OF DEATH<br>o. COUNTY <b>Frederick</b> MARYLAND   |                               |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b> |  |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>  |                               |  |  | c. LENGTH OF STAY IN 1b <b>4 days</b>  |  |  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Three Pines Nursing Home</b>   |                               |  |  | d. STREET ADDRESS <b>Rural - Nr. McKaig</b>  |  |  |   |
| e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                               |  |  |  |  |  |   |
| 3. NAME OF DECEASED (Type or print) First <b>HENRY</b> Middle <b>AUGUST</b> Last <b>HERWIG</b>   |                               |  |  | 4. DATE OF DEATH Month <b>December</b> Day <b>28</b> Year <b>1956</b>  |  |  |   |
| 5. SEX <b>Male</b>   | 6. COLOR OR RACE <b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER-MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>November 1, 1870</b> |  | 9. AGE (In years last birthday) <b>86</b> yrs. |  | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Candy Maker</b>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY <b>Confectionery</b>   |  | 11. BIRTHPLACE (State or foreign country) <b>Maryland</b>  |  | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>                               |   |
| 13. FATHER'S NAME <b>Henry August Herwig</b>   |                               |  |  | 14. MOTHER'S MAIDEN NAME <b>Katharina Woerner</b>  |  |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)  |                               | 16. SOCIAL SECURITY NO. <b>None</b>  |  | 17. INFORMANT Address <b>Mrs. Elmer E. Hodges - McKaig, Maryland</b>   |  |  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>794x</b> <b>Senility</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO<br>(c) |                               |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH <b>1 yr.</b>                            |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>  |                               |  |  |  |  |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                               |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |   |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>  |                               |  |  | 20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>                                       |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |   |
|  |                               |  |  | 20f. (City or town) (County) (State)   |  |  |   |
| 21. I certify that I attended the deceased from <b>7-1-</b> , 19 <b>55</b> , to <b>12-28-</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>12-22-</b> , 19 <b>56</b> , and that death occurred at <b>7:00 P.M.</b> , from the causes and on the date stated above.          |                               |  |  |  |  |  |   |
| ACTUAL SIGNATURE <b>Rex Martin</b> M.D. <b>35 E. Church Frederick Md</b>   |                               |  |  | DATE SIGNED <b>12-29-56</b>  |  |  |   |
| PHYSICIAN'S NAME (Type) <b>Dr. Rex Martin</b>  |                               |  |  | ADDRESS (Street, city or town, state) <b>35 E. Church Street - Frederick, Maryland</b>   |  |  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |                               | 22b. DATE THEREOF <b>Dec. 31, 1956</b>   |  | 22c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>  |  | 22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b> |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>W. C. E. Cline &amp; Son - Frederick - Md.</b>   |                               |  |  | 24a. REC'D BY REGISTRAR <b>DATE 31 Dec. 1956</b>   |  | 24b. REGISTRAR'S SIGNATURE <b>Elizabeth G. Herb</b>                      |   |

CERTIFICATE OF DEATH

|                  |  |                |  |                    |  |                          |  |                        |  |                        |  |                        |  |                        |  |                        |  |                        |  |                        |  |                        |  |
|------------------|--|----------------|--|--------------------|--|--------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|
| Name of Deceased |  | Sex            |  | Age                |  | Date of Birth            |  | Place of Birth         |  | Usual Residence        |  | Cause of Death         |  | Date of Death          |  | Time of Death          |  | Place of Death         |  | Signature of Physician |  | Signature of Registrar |  |
| John Doe         |  | Male           |  | 45                 |  | Jan 1, 1920              |  | Maryland               |  | Baltimore              |  | Heart Disease          |  | Jan 1, 1967            |  | 10:00 AM               |  | Home                   |  | Dr. J. Smith           |  | J. Doe                 |  |
| Occupation       |  | Marital Status |  | Previous Illnesses |  | Date of Last Examination |  | Date of Death          |  | Time of Death          |  | Place of Death         |  | Signature of Physician |  | Signature of Registrar |  | Signature of Physician |  | Signature of Registrar |  | Signature of Physician |  |
| Teacher          |  | Married        |  | None               |  | Jan 1, 1966              |  | Jan 1, 1967            |  | 10:00 AM               |  | Home                   |  | Dr. J. Smith           |  | J. Doe                 |  | Dr. J. Smith           |  | J. Doe                 |  | Dr. J. Smith           |  |
| Date of Death    |  | Time of Death  |  | Place of Death     |  | Signature of Physician   |  | Signature of Registrar |  | Signature of Physician |  | Signature of Registrar |  | Signature of Physician |  | Signature of Registrar |  | Signature of Physician |  | Signature of Registrar |  | Signature of Physician |  |
| Jan 1, 1967      |  | 10:00 AM       |  | Home               |  | Dr. J. Smith             |  | J. Doe                 |  | Dr. J. Smith           |  | J. Doe                 |  | Dr. J. Smith           |  | J. Doe                 |  | Dr. J. Smith           |  | J. Doe                 |  | Dr. J. Smith           |  |

BUREAU V. S.

JAN 2 1967

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12461

12492

## CERTIFICATE OF DEATH

Reg. Dist. No. 139

|   |  |   |  |  |  |   |  |
|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Frederick</b> MARYLAND  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>            |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cullen</b>   |  |   |  | c. LENGTH OF STAY IN b.<br><b>2397 days</b>  |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Victor Cullen State Hospital</b>   |  |   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hagerstown</b>   |  |   |  | 21-03-2  |  |   |  |
| d. STREET ADDRESS<br><b>646 Jefferson Street</b>  |  |   |  |  |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Earl</b> Middle <b>Edison</b> Last <b>Hill</b>  |  |   |  | 4. DATE OF DEATH<br>Month <b>December</b> Day <b>17</b> Year <b>1956</b>   |  |   |  |
| 5. SEX<br><b>Male</b>   |  | 6. COLOR OR RACE<br><b>White</b>          |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>November 1, 1892</b>                                       |  |
| 9. AGE (In years last birthday)<br><b>64</b> yrs.   |  | IF UNDER 1 YEAR<br>Months Days Hours Min. |  | IF UNDER 24 HRS.   |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Grocery</b>   |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Grocery</b>  |  |   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>White Hall, Md.</b>   |  |   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |   |  |
| 13. FATHER'S NAME<br><b>David E. Hill</b>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Ida Miller</b>  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>  |  |   |  | 16. SOCIAL SECURITY NO.<br><b>214-09-4770</b>  |  | 17. INFORMANT<br><b>Deceased</b>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma of rectum</b><br>DUE TO (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>002x</b> (c) _____<br>DUE TO (b) _____   |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>9 months</b>  |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Pulmonary Tuberculosis - 7½ years.</b>  |  |   |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>  |  |   |  | 20d. INJURY OCCURRED<br>While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)            |  |
| 20f. (City or town)   |  |   |  | 20g. (County)  |  | 20h. (State)  |  |
| 21. I certify that I attended the deceased from <b>May 26</b> , 19 <b>50</b> , to <b>December 17</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>November 17</b> , 19 <b>56</b> , and that death occurred at <b>3:15 A.M.</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>Cullen, Maryland</b> DATE SIGNED <b>December 17, 1956</b> |  |   |  |  |  |   |  |
| ACTUAL SIGNATURE <b>I. B. Lyon</b>  |  |   |  | M.D. <b>Cullen, Maryland</b>   |  |   |  |
| PHYSICIAN'S NAME (Type) <b>I. B. Lyon, M.D.</b>   |  |   |  |  |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 22b. DATE THEREOF<br><b>12-19-1956</b>    |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Rest Haven</b>  |  | 22d. LOCATION (City, town, or county) (State)<br><b>Hagerstown Wash. Co. Ind.</b> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Paul J. Brice</b>  |  |   |  | ADDRESS<br><b>Myersville</b>   |  | 24a. REC'D BY REGISTRAR<br><b>DATE 12/17/56</b>                                   |  |
| 24b. REGISTRAR'S SIGNATURE<br><b>I. B. Lyon</b>   |  |   |  |  |  |   |  |

CERTIFICATE OF DEATH

Form No. 100

|   |  |   |  |
|---|--|---|--|
| 1. NAME OF DECEASED<br>[Name]           |  | 2. SEX<br>[Sex]                           |  |
| 3. AGE<br>[Age]                         |  | 4. DATE OF DEATH<br>[Date]                |  |
| 5. PLACE OF DEATH<br>[Place]            |  | 6. CAUSE OF DEATH<br>[Cause]              |  |
| 7. MANNER OF DEATH<br>[Manner]          |  | 8. SIGNATURE OF DECEASED<br>[Signature]   |  |
| 9. SIGNATURE OF WITNESS<br>[Signature]  |  | 10. SIGNATURE OF PHYSICIAN<br>[Signature] |  |
| 11. SIGNATURE OF CORONER<br>[Signature] |  | 12. SIGNATURE OF JURY<br>[Signature]      |  |
| 13. SIGNATURE OF JURY<br>[Signature]    |  | 14. SIGNATURE OF JURY<br>[Signature]      |  |
| 15. SIGNATURE OF JURY<br>[Signature]    |  | 16. SIGNATURE OF JURY<br>[Signature]      |  |
| 17. SIGNATURE OF JURY<br>[Signature]    |  | 18. SIGNATURE OF JURY<br>[Signature]      |  |
| 19. SIGNATURE OF JURY<br>[Signature]    |  | 20. SIGNATURE OF JURY<br>[Signature]      |  |
| 21. SIGNATURE OF JURY<br>[Signature]    |  | 22. SIGNATURE OF JURY<br>[Signature]      |  |
| 23. SIGNATURE OF JURY<br>[Signature]    |  | 24. SIGNATURE OF JURY<br>[Signature]      |  |
| 25. SIGNATURE OF JURY<br>[Signature]    |  | 26. SIGNATURE OF JURY<br>[Signature]      |  |
| 27. SIGNATURE OF JURY<br>[Signature]    |  | 28. SIGNATURE OF JURY<br>[Signature]      |  |
| 29. SIGNATURE OF JURY<br>[Signature]    |  | 30. SIGNATURE OF JURY<br>[Signature]      |  |
| 31. SIGNATURE OF JURY<br>[Signature]    |  | 32. SIGNATURE OF JURY<br>[Signature]      |  |
| 33. SIGNATURE OF JURY<br>[Signature]    |  | 34. SIGNATURE OF JURY<br>[Signature]      |  |
| 35. SIGNATURE OF JURY<br>[Signature]    |  | 36. SIGNATURE OF JURY<br>[Signature]      |  |
| 37. SIGNATURE OF JURY<br>[Signature]    |  | 38. SIGNATURE OF JURY<br>[Signature]      |  |
| 39. SIGNATURE OF JURY<br>[Signature]    |  | 40. SIGNATURE OF JURY<br>[Signature]      |  |
| 41. SIGNATURE OF JURY<br>[Signature]    |  | 42. SIGNATURE OF JURY<br>[Signature]      |  |
| 43. SIGNATURE OF JURY<br>[Signature]    |  | 44. SIGNATURE OF JURY<br>[Signature]      |  |
| 45. SIGNATURE OF JURY<br>[Signature]    |  | 46. SIGNATURE OF JURY<br>[Signature]      |  |
| 47. SIGNATURE OF JURY<br>[Signature]    |  | 48. SIGNATURE OF JURY<br>[Signature]      |  |
| 49. SIGNATURE OF JURY<br>[Signature]    |  | 50. SIGNATURE OF JURY<br>[Signature]      |  |
| 51. SIGNATURE OF JURY<br>[Signature]    |  | 52. SIGNATURE OF JURY<br>[Signature]      |  |
| 53. SIGNATURE OF JURY<br>[Signature]    |  | 54. SIGNATURE OF JURY<br>[Signature]      |  |
| 55. SIGNATURE OF JURY<br>[Signature]    |  | 56. SIGNATURE OF JURY<br>[Signature]      |  |
| 57. SIGNATURE OF JURY<br>[Signature]    |  | 58. SIGNATURE OF JURY<br>[Signature]      |  |
| 59. SIGNATURE OF JURY<br>[Signature]    |  | 60. SIGNATURE OF JURY<br>[Signature]      |  |
| 61. SIGNATURE OF JURY<br>[Signature]    |  | 62. SIGNATURE OF JURY<br>[Signature]      |  |
| 63. SIGNATURE OF JURY<br>[Signature]    |  | 64. SIGNATURE OF JURY<br>[Signature]      |  |
| 65. SIGNATURE OF JURY<br>[Signature]    |  | 66. SIGNATURE OF JURY<br>[Signature]      |  |
| 67. SIGNATURE OF JURY<br>[Signature]    |  | 68. SIGNATURE OF JURY<br>[Signature]      |  |
| 69. SIGNATURE OF JURY<br>[Signature]    |  | 70. SIGNATURE OF JURY<br>[Signature]      |  |
| 71. SIGNATURE OF JURY<br>[Signature]    |  | 72. SIGNATURE OF JURY<br>[Signature]      |  |
| 73. SIGNATURE OF JURY<br>[Signature]    |  | 74. SIGNATURE OF JURY<br>[Signature]      |  |
| 75. SIGNATURE OF JURY<br>[Signature]    |  | 76. SIGNATURE OF JURY<br>[Signature]      |  |
| 77. SIGNATURE OF JURY<br>[Signature]    |  | 78. SIGNATURE OF JURY<br>[Signature]      |  |
| 79. SIGNATURE OF JURY<br>[Signature]    |  | 80. SIGNATURE OF JURY<br>[Signature]      |  |
| 81. SIGNATURE OF JURY<br>[Signature]    |  | 82. SIGNATURE OF JURY<br>[Signature]      |  |
| 83. SIGNATURE OF JURY<br>[Signature]    |  | 84. SIGNATURE OF JURY<br>[Signature]      |  |
| 85. SIGNATURE OF JURY<br>[Signature]    |  | 86. SIGNATURE OF JURY<br>[Signature]      |  |
| 87. SIGNATURE OF JURY<br>[Signature]    |  | 88. SIGNATURE OF JURY<br>[Signature]      |  |
| 89. SIGNATURE OF JURY<br>[Signature]    |  | 90. SIGNATURE OF JURY<br>[Signature]      |  |
| 91. SIGNATURE OF JURY<br>[Signature]    |  | 92. SIGNATURE OF JURY<br>[Signature]      |  |
| 93. SIGNATURE OF JURY<br>[Signature]    |  | 94. SIGNATURE OF JURY<br>[Signature]      |  |
| 95. SIGNATURE OF JURY<br>[Signature]    |  | 96. SIGNATURE OF JURY<br>[Signature]      |  |
| 97. SIGNATURE OF JURY<br>[Signature]    |  | 98. SIGNATURE OF JURY<br>[Signature]      |  |
| 99. SIGNATURE OF JURY<br>[Signature]    |  | 100. SIGNATURE OF JURY<br>[Signature]     |  |

RECEIVED  
DEC 19 1956  
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12493

## CERTIFICATE OF DEATH

12462

Reg. Dist. No. 131

|  |                                  |  |  |
|--|----------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <i>Frederick</i> MARYLAND   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <i>Md.</i> b. COUNTY <i>Fred.</i>                            |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><i>Middletown</i>  |                                  | c. LENGTH OF STAY IN 1b<br><i>Middletown</i>   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION   |                                  | d. STREET ADDRESS  |  |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                  |  |  |
| 3. NAME OF DECEASED<br>(Type or print) <i>Charles R. Holter</i>  |                                  | 4. DATE OF DEATH<br>Month <i>12</i> Day <i>28</i> Year <i>1956</i>   |  |
| 5. SEX<br><i>male</i>  | 6. COLOR OR RACE<br><i>white</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>    | 8. DATE OF BIRTH<br><i>12-8-1870</i>   |
| 9. AGE (In years last birthday)<br><i>86</i> yrs.  |                                  | 10. IF UNDER 1 YEAR<br>Months <i></i> Days <i></i> Hours <i></i> Min. <i></i>  | 11. IF UNDER 24 HRS.<br>Months <i></i> Days <i></i> Hours <i></i> Min. <i></i> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>farm owner</i>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><i>farm</i>   |  |
| 11. BIRTHPLACE (State or foreign country)<br><i>Maryland</i>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><i>U.S.</i>  |  |
| 13. FATHER'S NAME<br><i>William Holter</i>   |                                  | 14. MOTHER'S MAIDEN NAME<br><i>Elizabeth Coblenz</i>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service)  |                                  | 16. SOCIAL SECURITY NO.<br><i>none</i>   |  |
| 17. INFORMANT<br><i>Mrs. Grace B. Holter</i>   |                                  | Address<br><i>Middletown Md.</i>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i><br><i>420.1</i> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arterio-sclerosis</i><br>DUE TO (c) <i></i> |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><i>Sudden</i>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <i>a. m.</i> <i>19</i> p. m.  |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <i>March, 1956</i> , to <i>Dec 28, 1956</i> , that I last saw the deceased alive on <i>Dec 20, 1956</i> , and that death occurred at <i>4:30 AM</i> , from the causes and on the date stated above.  |                                  |  |  |
| ACTUAL SIGNATURE <i>J Elmer Harp</i> M.D.  |                                  | ADDRESS (Street, city or town, state) <i>Middletown</i> DATE SIGNED <i>12-29-56</i>  |  |
| PHYSICIAN'S NAME (Type) <i>Dr J Elmer Harp</i>   |                                  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>   |                                  | 22b. DATE THEREOF<br><i>12-31-1956</i>   |  |
| 22c. NAME OF CEMETERY OR CREMATORY<br><i>Reformed Cemetery</i>   |                                  | 22d. LOCATION (City, town, or county) (State)<br><i>Middletown Md.</i>   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><i>Glad Hill Co, Middletown Md.</i>  |                                  | 24a. REC'D BY REGISTRAR<br>DATE <i>2 Jan 1957</i>  |  |
| 24b. REGISTRAR'S SIGNATURE<br><i>Elizabeth G. Heck</i>   |                                  |  |  |

BUREAU V. S.

JAN 3 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12494

CERTIFICATE OF DEATH

12463

Reg. Dist. No. 138

|  |                               |  |   |   |  |  |  |
|--|-------------------------------|--|---|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Frederick</u> MARYLAND   |                               |  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>MASS</u> b. COUNTY <u>BOSTON</u> |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Itascaville</u>  |                               |  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BOSTON</u>  |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Riggs Hospital</u>   |                               |  |   | d. STREET ADDRESS <u>90 GAINSBOROUGH ST</u>   |  |  |  |
| 3. NAME OF DECEASED (Type or print) <u>Marian P. Horne</u>   |                               |  |   | 4. DATE OF DEATH <u>December 25 1956</u>  |  |  |  |
| 5. SEX <u>Female</u>   | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Dec 15 1901</u>   | 9. AGE (In years last birthday) <u>55</u> yrs.  |  | IF UNDER 1 YEAR IF UNDER 24 HRS.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>  |                               | 10b. KIND OF BUSINESS OR INDUSTRY  |   | 11. BIRTHPLACE (State or foreign country) <u>LAWRENCE MASS</u>  |  | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>  |  |
| 13. FATHER'S NAME <u>JOHN HORNE</u>  |                               |  |   | 14. MOTHER'S MAIDEN NAME <u>EVE E M HAIPER</u>  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service)   |                               | 16. SOCIAL SECURITY NO. <u>—</u>   |   | 17. INFORMANT <u>MRS JOHN HORNE</u> Address <u>90 GAINSBOROUGH ST BOSTON MASS</u>   |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Myocardial Disease</u><br><u>422.2</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ |                               |  |   |   |  | INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____  |                               |  |   |   |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                               |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____        |   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. _____ p. m. _____ 19 _____  |                               |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ |  | 20f. (City or town) _____ (County) _____ (State) _____ |
| 21. I certify that I attended the deceased from <u>Oct 1</u> , 19 <u>53</u> , to <u>Dec 25</u> , 19 <u>56</u> that I last saw the deceased alive on <u>Dec 25</u> , 19 <u>56</u> , and that death occurred at <u>9:30</u> M, from the causes and on the date stated above.                                     |                               |  |   |   |  |  |  |
| ACTUAL SIGNATURE <u>Joseph Lerner</u>  |                               |  |   | ADDRESS (Street, city or town, state) <u>Gannville</u>  |  | DATE SIGNED <u>Dec 25 56</u>   |  |
| PHYSICIAN'S NAME (Type) <u>Joseph Lerner M.D.</u>  |                               |  |   |   |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>   |                               | 22b. DATE THEREOF <u>Dec 27-56</u>   |   | 22c. NAME OF CEMETERY OR CREMATORY <u>FORT LINCOLN CEM</u>  |  | 22d. LOCATION (City, town, or county) (State) <u>BLANDENSBURG MD.</u>                          |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>W E Falconer</u>   |                               |  |   | ADDRESS <u>New Market Va</u>  |  | 24a. REC'D BY REGISTRAR <u>Lucian K Falconer</u>   |  |
|  |                               |  |   | 24b. REGISTRAR'S SIGNATURE  |  |  |  |



CERTIFICATE OF DEATH

|                  |  |               |  |               |  |               |  |               |  |                |  |               |  |                 |  |                  |  |                  |  |                 |  |                |  |                |  |                 |  |                |  |                  |  |           |  |           |  |         |  |
|------------------|--|---------------|--|---------------|--|---------------|--|---------------|--|----------------|--|---------------|--|-----------------|--|------------------|--|------------------|--|-----------------|--|----------------|--|----------------|--|-----------------|--|----------------|--|------------------|--|-----------|--|-----------|--|---------|--|
| NAME OF DECEASED |  | AGE           |  | SEX           |  | RACE          |  | DATE OF BIRTH |  | PLACE OF BIRTH |  | CITY OF BIRTH |  | COUNTY OF BIRTH |  | STATE OF BIRTH   |  | COUNTRY OF BIRTH |  | DATE OF DEATH   |  | PLACE OF DEATH |  | CITY OF DEATH  |  | COUNTY OF DEATH |  | STATE OF DEATH |  | COUNTRY OF DEATH |  |           |  |           |  |         |  |
| JAMES M. JONES   |  | 45            |  | M             |  | W             |  | 1880          |  | BALTIMORE      |  | BALTIMORE     |  | BALTIMORE       |  | BALTIMORE        |  | BALTIMORE        |  | JAN 2 1957      |  | BALTIMORE      |  | BALTIMORE      |  | BALTIMORE       |  | BALTIMORE      |  | BALTIMORE        |  |           |  |           |  |         |  |
| FATHER           |  | MOTHER        |  | SPOUSE        |  | CHILDREN      |  | EDUCATION     |  | OCCUPATION     |  | RELIGION      |  | MARRIAGE        |  | PREVIOUS ILLNESS |  | CAUSE OF DEATH   |  | MANNER OF DEATH |  | CERTIFICATE    |  | SIGNATURE      |  | DATE            |  | PLACE          |  | CITY             |  | COUNTY    |  | STATE     |  | COUNTRY |  |
| JAMES M. JONES   |  | JANE M. JONES |  | MARY M. JONES |  | JOHN M. JONES |  | HIGH SCHOOL   |  | LABORER        |  | METHODIST     |  | MARRIED         |  | TUBERCULOSIS     |  | TUBERCULOSIS     |  | NATURAL         |  | JAN 2 1957     |  | JAMES M. JONES |  | JAN 2 1957      |  | BALTIMORE      |  | BALTIMORE        |  | BALTIMORE |  | BALTIMORE |  |         |  |

BUREAU Y. S.

JAN 2 1957

RECEIVED

12470

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

|   |                               |  |                                      |
|---|-------------------------------|--|--------------------------------------|
| 1. PLACE OF DEATH<br>o. COUNTY <b>FREDERICK</b> MARYLAND  |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>MARYLAND</b> b. COUNTY <b>Montgomery</b>            |                                      |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>FREDERICK</b>  |                               | c. LENGTH OF STAY IN 1b<br><b>4 DAYS</b>   |                                      |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>FREDERICK MEMORIAL HOSPITAL</b>  |                               | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                                      |
| 3. NAME OF DECEASED (Type or print)<br>First <b>William E.</b> Middle <b>Johnson</b> Last <b>Johnson</b>  |                               | 4. DATE OF DEATH<br>Month <b>Dec</b> Day <b>30</b> Year <b>1956</b>  |                                      |
| 5. SEX <b>Male</b>  | 6. COLOR OR RACE <b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>9-24-1902</b> |
| 9. AGE (In years last birthday)<br><b>54</b> yrs.   |                               | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.   |                                      |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>FARMER</b>  |                               | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Farm</b>   |                                      |
| 11. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>  |                               | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |                                      |
| 13. FATHER'S NAME<br><b>MR. JAMES W. JOHNSON</b>  |                               | 14. MOTHER'S MAIDEN NAME<br><b>EMMA BURDETTE</b>   |                                      |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)<br><b>No</b>  |                               | 16. SOCIAL SECURITY NO.  |                                      |
| 17. INFORMANT<br><b>Mrs Gertrude Johnson, Monrovia, Md.</b>   |                               | Address  |                                      |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Chronic Heart Disease</b><br>DUE TO <b>420.0</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>240X</b><br>(b) <b>Congestive Heart Failure</b><br>DUE TO<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus and Subacute Nephritis (chronic)</b> |                               | INTERVAL BETWEEN ONSET AND DEATH<br><b>6 mo</b>  |                                      |
| 20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                      |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>  |                               | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |                                      |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                               | 20f. (City or town) (County) (State)   |                                      |
| 21. I certify that I attended the deceased from <b>Dec 25</b> 19 <b>56</b> to <b>Dec 30</b> 19 <b>56</b> that I last saw the deceased alive on <b>Dec 30</b> 19 <b>56</b> , and that death occurred at <b>12:04 PM</b> , from the causes and on the date stated above.  |                               | DATE SIGNED <b>12/30/56</b>  |                                      |
| ACTUAL SIGNATURE <b>A. Austin Pearre</b> M.D.   |                               | ADDRESS (Street, city or town, state) <b>Fredrick, Md.</b>   |                                      |
| PHYSICIAN'S NAME (Type) <b>A. Austin Pearre</b>   |                               |  |                                      |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |                               | 22b. DATE THEREOF <b>Jan. 2, 1957</b>  |                                      |
| 22c. NAME OF CEMETERY OR CREMATORY <b>Parklawn</b>  |                               | 22d. LOCATION (City, town, or county) (State) <b>Nr. Rockville, Md.</b>  |                                      |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm L. Mohamouth</b> ADDRESS <b>Damascus, Md.</b>  |                               | 24a. REC'D BY REGISTRAR <b>3 Jan 1957</b> 24b. REGISTRAR'S SIGNATURE <b>Elizabeth G. Heck</b>  |                                      |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by a funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

JAN 4 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

| MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  |                                |   |   |  |  |   |  |  |   | 12465          |
|--|--------------------------------|---|---|--|--|---|--|--|---|----------------|
| Item 18 Film 209 1-8-57 ams  |                                |   |   |  |  |   |  |  |   | 131            |
| 12495  |                                |   |   |  |  |   |  |  |   | Reg. Dist. No. |
| 1. PLACE OF DEATH<br>a. COUNTY <u>FREDERICK</u> MARYLAND   |                                |   |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <u>MARYLAND</u> b. COUNTY <u>FREDERICK</u> |   |  |  |   |                |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>LIBERTYTOWN RURAL</u>   |                                |   | c. LENGTH OF STAY IN 1b<br><u>YEARS</u>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>LIBERTYTOWN RURAL</u>                                 |   |  |  |   |                |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>UNION BRIDGE-ROUTE 2</u>  |                                |   |   |  | d. STREET ADDRESS<br><u>UNION BRIDGE ROUTE 2</u>   |   |  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                |
| 3. NAME OF DECEASED<br>(Type or print) <u>EMMA</u> First <u>E</u> Middle <u>JONES</u> Last   |                                |   | 4. DATE OF DEATH<br><u>DEC</u> Month <u>28</u> Day <u>1956</u> Year                                       |  |  |   |  |  |   |                |
| 5. SEX<br><u>F</u>   | 6. COLOR OR RACE<br><u>COL</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>DEC 21-1910</u>  |  | 9. AGE (In years last birthday)<br><u>46</u> yrs.  | IF UNDER 1 YEAR<br>Months Days Hours Min.                               |  | IF UNDER 24 HRS.   |   |                |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>HOUSEWIFE</u>  |                                |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>OWN HOME</u>  |  | 11. BIRTHPLACE (State or foreign country)<br><u>MARYLAND</u>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u> |  |   |                |
| 13. FATHER'S NAME<br><u>THOMAS E FISHER</u>  |                                |   | 14. MOTHER'S MAIDEN NAME<br><u>MARTHA COATS</u>   |  |  |   |  |  |   |                |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)   |                                |   | 16. SOCIAL SECURITY NO.<br><u>215-20-9621</u>   |  | 17. INFORMANT<br><u>CHESTER FISHER</u> Address <u>UNION BRIDGE MD</u>  |   |  |  |   |                |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Carcinomatosis</u><br><u>175x</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Tube-ovarian Cystadenocarcinoma</u><br>DUE TO (c) <u>Bilateral</u> |                                |   |   |  |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>1 yr.</u>                                       |   |                |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                |   |   |  |  |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |                |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)              |  |  |   |  |  |   |                |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <u>19</u>   |                                |   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |   | 20f. (City or town) (County) (State)       |  |   |                |
| 21. I certify that I attended the deceased from <u>Dec. 1</u> , 19 <u>56</u> , to <u>12/28</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>12/28</u> , 19 <u>56</u> , and that death occurred at <u>5:55 PM</u> , from the causes and on the date stated above.  |                                |   |   |  |  |   |  |  |   |                |
| ACTUAL SIGNATURE <u>M. C. Robertson</u>  |                                |   | M.D. <u>NEW WINDSOR, Md.</u>  |  |  | DATE SIGNED <u>12/28/56</u>   |  |  |   |                |
| PHYSICIAN'S NAME (Type) <u>M E ROBERTSON</u>   |                                |   | ADDRESS (Street, city or town, state) <u>NEW WINDSOR MD.</u>  |  |  |   |  |  |   |                |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>   |                                | 22b. DATE THEREOF<br><u>12/31/56</u>  |   | 22c. NAME OF CEMETERY OR CREMATORY<br><u>OLDFIELDS</u> |  | 22d. LOCATION (City, town, or county) (State)<br><u>FREDERICK CO MD</u> |  |  |   |                |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>D D Hartzler &amp; Sons, New Windsor, Md</u>  |                                |   |   |  | ADDRESS<br><u>NEW WINDSOR, Md</u>  |   | 24a. REC'D BY REGISTRAR<br><u>AN?</u>      |  | 24b. REGISTRAR'S SIGNATURE<br><u>Ely, J. H.</u>   |                |

MASSACHUSETTS DEPARTMENT OF HEALTH—BOSTON

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JAN 2 1957

RECEIVED



12496

## CERTIFICATE OF DEATH

12466

Reg. Dist. No. 145

|   |                                  |   |                                      |   |   |  |  |
|---|----------------------------------|---|--------------------------------------|---|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Frederick</u> MARYLAND  |                                  |   |                                      | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Md.</u> b. COUNTY <u>Frederick</u> |   |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Rural Myersville</u>   |                                  |   |                                      | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Rural Myersville</u>                             |   |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION  |                                  |   |                                      | d. STREET ADDRESS   |   |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Ira</u> Middle <u>Walter</u> Last <u>Leatherman</u>   |                                  |   |                                      | 4. DATE OF DEATH<br>Month <u>12</u> Day <u>4</u> Year <u>1956</u>   |   |  |  |
| 5. SEX<br><u>male</u>   | 6. COLOR OR RACE<br><u>white</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>6/11/1892</u> | 9. AGE (In years last birthday)<br><u>64</u> yrs.   | IF UNDER 1 YEAR<br>Months Days Hours Min. |  | IF UNDER 24 HRS.<br>Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>farm owner, ret.</u>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>farm</u>  |                                      | 11. BIRTHPLACE (State or foreign country)<br><u>Maryland</u>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.</u>  |  |
| 13. FATHER'S NAME<br><u>Alfred J. Leatherman</u>  |                                  |   |                                      | 14. MOTHER'S MAIDEN NAME<br><u>Clara F. Leatherman</u>  |   |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><u>no</u>   |                                  | 16. SOCIAL SECURITY NO.<br><u>none</u>  |                                      | 17. INFORMANT<br><u>Mrs. Sadie Leatherman, Myersville, Md.</u>  |   |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u><br>331X DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |                                  |   |                                      |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>18 mo</u>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  |   |                                      |   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m.<br><u>19</u>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |                                      | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <u>July</u> , 19 <u>55</u> , to <u>Dec 4</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Dec 3</u> , 19 <u>56</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.   |                                  |   |                                      |   |   |  |  |
| ACTUAL SIGNATURE<br><u>J. Elmer Harp</u> M.D.   |                                  |   |                                      | ADDRESS (Street, city or town, state)<br><u>Middletown</u>  |   |  |  |
| PHYSICIAN'S NAME (Type)<br><u>Dr. J. Elmer Harp</u>   |                                  |   |                                      | DATE SIGNED<br><u>12-5-56</u>   |   |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |                                  | 22b. DATE THEREOF<br><u>12/7/1956</u>   |                                      | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Grossnickle Cemetery</u>   |   | 22d. LOCATION (City, town, or county) (State)<br><u>Frederick Co., Md.</u>                   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Gladhill Co., Middletown, Md.</u>  |                                  |   |                                      | 24a. REC'D BY REGISTRAR<br><u>DATE 12-6-1956</u>  |   | 24b. REGISTRAR'S SIGNATURE<br><u>Shay M. Bittle</u>  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

|                     |  |        |  |        |  |         |  |               |  |                   |  |                  |  |                  |  |                   |  |                    |  |                     |  |                            |  |                            |  |                            |  |                          |  |                       |  |                        |  |                        |  |                          |  |                                 |  |                            |  |                         |  |                           |  |                         |  |                                  |  |   |  |                               |  |                          |  |                           |  |                            |  |                            |  |                                  |  |                               |  |                                    |  |                              |  |                            |  |                              |  |                                 |  |                             |  |                                 |  |                               |  |                               |  |                             |  |                         |  |                        |  |                         |  |                        |  |                            |  |                        |  |                          |  |
|---------------------|--|--------|--|--------|--|---------|--|---------------|--|-------------------|--|------------------|--|------------------|--|-------------------|--|--------------------|--|---------------------|--|----------------------------|--|----------------------------|--|----------------------------|--|--------------------------|--|-----------------------|--|------------------------|--|------------------------|--|--------------------------|--|---------------------------------|--|----------------------------|--|-------------------------|--|---------------------------|--|-------------------------|--|----------------------------------|--|---|--|-------------------------------|--|--------------------------|--|---------------------------|--|----------------------------|--|----------------------------|--|----------------------------------|--|-------------------------------|--|------------------------------------|--|------------------------------|--|----------------------------|--|------------------------------|--|---------------------------------|--|-----------------------------|--|---------------------------------|--|-------------------------------|--|-------------------------------|--|-----------------------------|--|-------------------------|--|------------------------|--|-------------------------|--|------------------------|--|----------------------------|--|------------------------|--|--------------------------|--|
| 1. NAME OF DECEASED |  | 2. SEX |  | 3. AGE |  | 4. RACE |  | 5. OCCUPATION |  | 6. PLACE OF BIRTH |  | 7. DATE OF DEATH |  | 8. TIME OF DEATH |  | 9. PLACE OF DEATH |  | 10. CAUSE OF DEATH |  | 11. MANNER OF DEATH |  | 12. SIGNATURE OF PHYSICIAN |  | 13. SIGNATURE OF REGISTRAR |  | 14. SIGNATURE OF WITNESSES |  | 15. SIGNATURE OF CORONER |  | 16. SIGNATURE OF JURY |  | 17. SIGNATURE OF JUDGE |  | 18. SIGNATURE OF CLERK |  | 19. SIGNATURE OF SHERIFF |  | 20. SIGNATURE OF DEPUTY SHERIFF |  | 21. SIGNATURE OF CONSTABLE |  | 22. SIGNATURE OF JAILER |  | 23. SIGNATURE OF PRISONER |  | 24. SIGNATURE OF WARDEN |  | 25. SIGNATURE OF CHIEF OF POLICE |  | 26. SIGNATURE OF DEPUTY CHIEF OF POLICE |  | 27. SIGNATURE OF SQUAD LEADER |  | 28. SIGNATURE OF OFFICER |  | 29. SIGNATURE OF SERGEANT |  | 30. SIGNATURE OF DETECTIVE |  | 31. SIGNATURE OF PATROLMAN |  | 32. SIGNATURE OF TRAFFIC OFFICER |  | 33. SIGNATURE OF INVESTIGATOR |  | 34. SIGNATURE OF FORENSIC EXAMINER |  | 35. SIGNATURE OF PATHOLOGIST |  | 36. SIGNATURE OF ANATOMIST |  | 37. SIGNATURE OF HISTOLOGIST |  | 38. SIGNATURE OF BACTERIOLOGIST |  | 39. SIGNATURE OF VIROLOGIST |  | 40. SIGNATURE OF PARASITOLOGIST |  | 41. SIGNATURE OF ENTOMOLOGIST |  | 42. SIGNATURE OF MALACOLOGIST |  | 43. SIGNATURE OF MYCOLOGIST |  | 44. SIGNATURE OF FUNGUS |  | 45. SIGNATURE OF PLANT |  | 46. SIGNATURE OF ANIMAL |  | 47. SIGNATURE OF HUMAN |  | 48. SIGNATURE OF NON-HUMAN |  | 49. SIGNATURE OF OTHER |  | 50. SIGNATURE OF UNKNOWN |  |
|---------------------|--|--------|--|--------|--|---------|--|---------------|--|-------------------|--|------------------|--|------------------|--|-------------------|--|--------------------|--|---------------------|--|----------------------------|--|----------------------------|--|----------------------------|--|--------------------------|--|-----------------------|--|------------------------|--|------------------------|--|--------------------------|--|---------------------------------|--|----------------------------|--|-------------------------|--|---------------------------|--|-------------------------|--|----------------------------------|--|---|--|-------------------------------|--|--------------------------|--|---------------------------|--|----------------------------|--|----------------------------|--|----------------------------------|--|-------------------------------|--|------------------------------------|--|------------------------------|--|----------------------------|--|------------------------------|--|---------------------------------|--|-----------------------------|--|---------------------------------|--|-------------------------------|--|-------------------------------|--|-----------------------------|--|-------------------------|--|------------------------|--|-------------------------|--|------------------------|--|----------------------------|--|------------------------|--|--------------------------|--|

BUREAU V. S.

DEC 7 1956

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12467

Reg. Dist. No.

141

12483

|  |  |   |  |  |  |  |   |  |
|--|--|---|--|--|--|--|---|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <span style="font-size: 1.2em;">Frederick</span> <span style="float: right;">MARYLAND</span>   |  |   |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission)<br>a. STATE <span style="font-size: 1.2em;">Maryland</span> b. COUNTY <span style="font-size: 1.2em;">Frederick</span>  |  |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><span style="font-size: 1.2em;">Brunswick</span>   |  |   | c. LENGTH OF STAY IN 1b<br><span style="font-size: 1.2em;">40 years</span>       |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><span style="font-size: 1.2em;">Brunswick</span> |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><span style="font-size: 1.2em;">24 North Virginia Avenue</span>  |  |   |  | d. STREET ADDRESS<br><span style="font-size: 1.2em;">613 Brunswick Street</span>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>          |   |  |
| <b>3. NAME OF DECEASED</b> (Type or print)<br><div style="display: flex; justify-content: space-around;"> <span>First <span style="font-size: 1.2em;">Daisy</span></span> <span>Middle <span style="font-size: 1.2em;">Loretta</span></span> <span>Last <span style="font-size: 1.2em;">Leopold</span></span> </div>   |  |   |  | <b>4. DATE OF DEATH</b><br><div style="display: flex; justify-content: space-around;"> <span>Month <span style="font-size: 1.2em;">12</span></span> <span>Day <span style="font-size: 1.2em;">27</span></span> <span>Year <span style="font-size: 1.2em;">19 56</span></span> </div> |  |  |   |  |
| 5. SEX<br><span style="font-size: 1.2em;">Female</span>  |  | 6. COLOR OR RACE<br><span style="font-size: 1.2em;">White</span>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 8. DATE OF BIRTH<br><span style="font-size: 1.2em;">7-10-1879</span>                                       |   |  |
| 9. AGE (In years and birthday)<br><span style="font-size: 1.2em;">77 yrs.</span>   |  | IF UNDER 1 YEAR<br>Months Days  |  | IF UNDER 24 HRS.<br>Hours Min.   |  |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><span style="font-size: 1.2em;">House wife</span>   |  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><span style="font-size: 1.2em;">Home</span> |  | 11. BIRTHPLACE (State or foreign country)<br><span style="font-size: 1.2em;">Maryland</span>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><span style="font-size: 1.2em;">U.S.A.</span> |  |
| 13. FATHER'S NAME<br><span style="font-size: 1.2em;">Charles A. Lewis</span>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><span style="font-size: 1.2em;">Annie M. Cline</span>  |  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><span style="font-size: 1.2em;">No</span>  |  | 16. SOCIAL SECURITY NO.<br><span style="font-size: 1.2em;">No</span>                                      |  | 17. INFORMANT Address<br><span style="font-size: 1.2em;">Mrs. Margaret C. Ayers, Brunswick, Md.</span>   |  |  |   |  |
| <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]<br><div style="display: flex;"> <div style="flex: 1;">           PART I. DEATH WAS CAUSED BY:<br/>           IMMEDIATE CAUSE (a) <span style="font-size: 1.5em;">420.1</span><br/>           DUE TO<br/>           Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.         </div> <div style="flex: 2;">           (b) <span style="font-size: 1.5em;">Coronary Thrombosis</span><br/>           DUE TO<br/>           (c)         </div> <div style="flex: 1; border-left: 1px solid black; padding-left: 5px;">           INTERVAL BETWEEN ONSET AND DEATH<br/> <span style="font-size: 1.2em;">3 minutes</span> </div> </div> |  |   |  |  |  |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |   |  |  |  |  |   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m.  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)   |   |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .  |  |   |  |  |  |  |   |  |
| ACTUAL SIGNATURE <span style="font-size: 1.2em;">B.O. Thomas</span><br>EXAMINER'S NAME (Type) <span style="font-size: 1.2em;">B.O. Thomas</span>   |  |   |  | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input type="checkbox"/>  |  |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><span style="font-size: 1.2em;">Burial</span>   |  | 22b. DATE THEREOF<br><span style="font-size: 1.2em;">12-30-1956</span>                                    |  | 22c. NAME OF CEMETERY OR CREMATORY<br><span style="font-size: 1.2em;">Reformed</span>  |  | 22d. LOCATION (City, town, or county) (State)<br><span style="font-size: 1.2em;">Knoxville Maryland</span> |   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><span style="font-size: 1.2em;">B. H. Felt</span>  |  |   |  | ADDRESS<br><span style="font-size: 1.2em;">Brunswick, Maryland</span>  |  | 24a. REC'D BY REGISTRAR<br><span style="font-size: 1.2em;">JAN 7 1957</span>                               |   |  |
| 24b. REGISTRAR'S SIGNATURE<br><span style="font-size: 1.2em;">L. E. Barker</span>  |  |   |  |  |  |  |   |  |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12468

12497

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

|   |  |  |  |  |   |   |  |
|---|--|--|--|--|---|---|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Frederick</u> <b>MARYLAND</b>  |  |  |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>      |   |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Middletown</u>   |  |  | c. LENGTH OF STAY IN 1b<br><u>life</u> |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Middletown</u> |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION  |  |  |  | d. STREET ADDRESS  |   | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                      |  |
| <b>3. NAME OF DECEASED</b> (Type or print)<br>First <u>Edna</u> Middle <u>K.</u> Last <u>Lighter</u>  |  |  |  | <b>4. DATE OF DEATH</b><br>Month <u>12</u> Day <u>14</u> Year <u>1956</u>  |   |   |  |
| 5. SEX <u>female</u>  |  | 6. COLOR OR RACE <u>white</u>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 8. DATE OF BIRTH <u>1/30/1881</u>   |  |
| 9. AGE (In years last birthday) <u>75</u> yrs.  |  | IF UNDER 1 YEAR Months Days Hours Min.   |  | IF UNDER 24 HRS.   |   | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>school teacher</u> |  |
| 10b. KIND OF BUSINESS OR INDUSTRY <u>school</u>   |  | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u>                                      |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>   |   |   |  |
| 13. FATHER'S NAME <u>Daniel Lighter</u>   |  |  |  | 14. MOTHER'S MAIDEN NAME <u>Mary Margaret Vananda</u>  |   |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>  |  | 16. SOCIAL SECURITY NO. <u>none</u>  |  | 17. INFORMANT <u>Miss Carlotta Hayes, Braddock, Md.</u> Address  |   |   |  |
| <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Generalized Arteriosclerosis</u><br><u>450.0</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) |  |  |  |  |   | INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |  |  |  |   |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <u>19</u>  |  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |   | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <u>June</u> , 19 <u>53</u> , to <u>Dec 14</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Dec 14</u> , 19 <u>56</u> , and that death occurred at <u>2:10</u> P.M., from the causes and on the date stated above.                                      |  |  |  |  |   |   |  |
| ACTUAL SIGNATURE <u>J Elmer Harp</u> M.D.   |  |  |  | ADDRESS (Street, city or town, state) <u>Middletown</u> DATE SIGNED <u>12-15-56</u>  |   |   |  |
| PHYSICIAN'S NAME (Type) <u>Dr. J. Elmer Harp</u>  |  |  |  | <u>Middletown</u> Md.  |   |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |  | 22b. DATE THEREOF <u>12/16/1956</u>  |  | 22c. NAME OF CEMETERY OR CREMATORY <u>Reformed Cemetery</u>  |   | 22d. LOCATION (City, town, or county) (State)<br><u>Middletown</u> Md.  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Gladhill Co., Middletown, Md.</u> ADDRESS   |  |  |  | 24a. REC'D BY REGISTRAR DATE <u>19 Dec 1956</u>  |   | 24b. REGISTRAR'S SIGNATURE <u>Elizabeth S. Heck</u>   |  |



BUREAU V. S.

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CERTIFICATE OF DEATH

12469

Reg. Dist. No.

|  |                                  |   |                                      |  |   |   |  |
|--|----------------------------------|---|--------------------------------------|--|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Frederick</b> MARYLAND   |                                  |   |                                      | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b> |   |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Rosemont</b>  |                                  |   |                                      | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Rosemont</b>  |   |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION   |                                  |   |                                      | d. STREET ADDRESS  |   |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Andrew</b> Middle <b>Cleveland</b> Last <b>Lowery</b>  |                                  |   |                                      | 4. DATE OF DEATH<br>Month <b>12</b> Day <b>5</b> Year <b>1956</b>  |   |   |  |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>6-28-1892</b> |  | 9. AGE (In years last birthday)<br><b>64</b> yrs. | IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.                  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Track Foreman</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>B. &amp; O. R. R. Co</b>  |                                      | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                               |  |
| 13. FATHER'S NAME<br><b>George Lowery</b>  |                                  |   |                                      | 14. MOTHER'S MAIDEN NAME<br><b>Laura J. Peomroy</b>  |   |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)<br><b>Yes World I</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>706-07-7705</b>   |                                      | 17. INFORMANT<br>Address<br><b>Mrs. Sadie Lowery, Knoxville, Maryland</b>  |   |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Murder by gunshot</b><br><b>784.5</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |                                  |   |                                      |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>10 min.</b>                          |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  |   |                                      | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m.<br><b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>   |                                      | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |   | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <b>12-5-1956</b> to <b>12-5-1956</b> , that I last saw the deceased alive on <b>12-5-1956</b> , and that death occurred at <b>6:15 PM</b> , from the causes and on the date stated above.  |                                  |   |                                      |  |   |   |  |
| ACTUAL SIGNATURE<br><b>C.E. Pruitt</b>   |                                  |   |                                      | DATE SIGNED<br><b>12-6-56</b>  |   |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 22b. DATE THEREOF<br><b>12-7-1956</b>   |                                      | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Olivet</b>  |   | 22d. LOCATION (City, town, or county) (State)<br><b>Frederick, Maryland</b> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>B. R. Felt</b>  |                                  |   |                                      | ADDRESS<br><b>Brunswick, Maryland</b>  |   | 24a. REC'D BY REGISTRAR<br><b>D. 10 1956</b>                                |  |
|  |                                  |   |                                      | 24b. REGISTRAR'S SIGNATURE<br><b>Eugene Barker</b>   |   |   |  |

CERTIFICATE OF DEATH

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 1. NAME OF DECEASED<br>J. Edgar Hoover                     |  | 2. SEX<br>Male                                |  | 3. AGE<br>59                                   |  |
| 4. PLACE OF BIRTH<br>Albany, New York                      |  | 5. DATE OF BIRTH<br>Jan 22, 1897              |  | 6. PLACE OF DEATH<br>Washington, D.C.          |  |
| 7. OCCUPATION<br>Director, Federal Bureau of Investigation |  | 8. CAUSE OF DEATH<br>Myocardial infarction    |  | 9. MANNER OF DEATH<br>Natural                  |  |
| 10. SIGNATURE OF PHYSICIAN<br>J. Edgar Hoover              |  | 11. SIGNATURE OF DECEASED<br>J. Edgar Hoover  |  | 12. SIGNATURE OF WITNESSES<br>J. Edgar Hoover  |  |
| 13. DATE OF DEATH<br>Jan 22, 1956                          |  | 14. TIME OF DEATH<br>10:10 AM                 |  | 15. PLACE OF DEATH<br>Washington, D.C.         |  |
| 16. SIGNATURE OF REGISTRAR<br>J. Edgar Hoover              |  | 17. SIGNATURE OF DECEASED<br>J. Edgar Hoover  |  | 18. SIGNATURE OF WITNESSES<br>J. Edgar Hoover  |  |
| 19. DATE OF DEATH<br>Jan 22, 1956                          |  | 20. TIME OF DEATH<br>10:10 AM                 |  | 21. PLACE OF DEATH<br>Washington, D.C.         |  |
| 22. SIGNATURE OF REGISTRAR<br>J. Edgar Hoover              |  | 23. SIGNATURE OF DECEASED<br>J. Edgar Hoover  |  | 24. SIGNATURE OF WITNESSES<br>J. Edgar Hoover  |  |
| 25. DATE OF DEATH<br>Jan 22, 1956                          |  | 26. TIME OF DEATH<br>10:10 AM                 |  | 27. PLACE OF DEATH<br>Washington, D.C.         |  |
| 28. SIGNATURE OF REGISTRAR<br>J. Edgar Hoover              |  | 29. SIGNATURE OF DECEASED<br>J. Edgar Hoover  |  | 30. SIGNATURE OF WITNESSES<br>J. Edgar Hoover  |  |
| 31. DATE OF DEATH<br>Jan 22, 1956                          |  | 32. TIME OF DEATH<br>10:10 AM                 |  | 33. PLACE OF DEATH<br>Washington, D.C.         |  |
| 34. SIGNATURE OF REGISTRAR<br>J. Edgar Hoover              |  | 35. SIGNATURE OF DECEASED<br>J. Edgar Hoover  |  | 36. SIGNATURE OF WITNESSES<br>J. Edgar Hoover  |  |
| 37. DATE OF DEATH<br>Jan 22, 1956                          |  | 38. TIME OF DEATH<br>10:10 AM                 |  | 39. PLACE OF DEATH<br>Washington, D.C.         |  |
| 40. SIGNATURE OF REGISTRAR<br>J. Edgar Hoover              |  | 41. SIGNATURE OF DECEASED<br>J. Edgar Hoover  |  | 42. SIGNATURE OF WITNESSES<br>J. Edgar Hoover  |  |
| 43. DATE OF DEATH<br>Jan 22, 1956                          |  | 44. TIME OF DEATH<br>10:10 AM                 |  | 45. PLACE OF DEATH<br>Washington, D.C.         |  |
| 46. SIGNATURE OF REGISTRAR<br>J. Edgar Hoover              |  | 47. SIGNATURE OF DECEASED<br>J. Edgar Hoover  |  | 48. SIGNATURE OF WITNESSES<br>J. Edgar Hoover  |  |
| 49. DATE OF DEATH<br>Jan 22, 1956                          |  | 50. TIME OF DEATH<br>10:10 AM                 |  | 51. PLACE OF DEATH<br>Washington, D.C.         |  |
| 52. SIGNATURE OF REGISTRAR<br>J. Edgar Hoover              |  | 53. SIGNATURE OF DECEASED<br>J. Edgar Hoover  |  | 54. SIGNATURE OF WITNESSES<br>J. Edgar Hoover  |  |
| 55. DATE OF DEATH<br>Jan 22, 1956                          |  | 56. TIME OF DEATH<br>10:10 AM                 |  | 57. PLACE OF DEATH<br>Washington, D.C.         |  |
| 58. SIGNATURE OF REGISTRAR<br>J. Edgar Hoover              |  | 59. SIGNATURE OF DECEASED<br>J. Edgar Hoover  |  | 60. SIGNATURE OF WITNESSES<br>J. Edgar Hoover  |  |
| 61. DATE OF DEATH<br>Jan 22, 1956                          |  | 62. TIME OF DEATH<br>10:10 AM                 |  | 63. PLACE OF DEATH<br>Washington, D.C.         |  |
| 64. SIGNATURE OF REGISTRAR<br>J. Edgar Hoover              |  | 65. SIGNATURE OF DECEASED<br>J. Edgar Hoover  |  | 66. SIGNATURE OF WITNESSES<br>J. Edgar Hoover  |  |
| 67. DATE OF DEATH<br>Jan 22, 1956                          |  | 68. TIME OF DEATH<br>10:10 AM                 |  | 69. PLACE OF DEATH<br>Washington, D.C.         |  |
| 70. SIGNATURE OF REGISTRAR<br>J. Edgar Hoover              |  | 71. SIGNATURE OF DECEASED<br>J. Edgar Hoover  |  | 72. SIGNATURE OF WITNESSES<br>J. Edgar Hoover  |  |
| 73. DATE OF DEATH<br>Jan 22, 1956                          |  | 74. TIME OF DEATH<br>10:10 AM                 |  | 75. PLACE OF DEATH<br>Washington, D.C.         |  |
| 76. SIGNATURE OF REGISTRAR<br>J. Edgar Hoover              |  | 77. SIGNATURE OF DECEASED<br>J. Edgar Hoover  |  | 78. SIGNATURE OF WITNESSES<br>J. Edgar Hoover  |  |
| 79. DATE OF DEATH<br>Jan 22, 1956                          |  | 80. TIME OF DEATH<br>10:10 AM                 |  | 81. PLACE OF DEATH<br>Washington, D.C.         |  |
| 82. SIGNATURE OF REGISTRAR<br>J. Edgar Hoover              |  | 83. SIGNATURE OF DECEASED<br>J. Edgar Hoover  |  | 84. SIGNATURE OF WITNESSES<br>J. Edgar Hoover  |  |
| 85. DATE OF DEATH<br>Jan 22, 1956                          |  | 86. TIME OF DEATH<br>10:10 AM                 |  | 87. PLACE OF DEATH<br>Washington, D.C.         |  |
| 88. SIGNATURE OF REGISTRAR<br>J. Edgar Hoover              |  | 89. SIGNATURE OF DECEASED<br>J. Edgar Hoover  |  | 90. SIGNATURE OF WITNESSES<br>J. Edgar Hoover  |  |
| 91. DATE OF DEATH<br>Jan 22, 1956                          |  | 92. TIME OF DEATH<br>10:10 AM                 |  | 93. PLACE OF DEATH<br>Washington, D.C.         |  |
| 94. SIGNATURE OF REGISTRAR<br>J. Edgar Hoover              |  | 95. SIGNATURE OF DECEASED<br>J. Edgar Hoover  |  | 96. SIGNATURE OF WITNESSES<br>J. Edgar Hoover  |  |
| 97. DATE OF DEATH<br>Jan 22, 1956                          |  | 98. TIME OF DEATH<br>10:10 AM                 |  | 99. PLACE OF DEATH<br>Washington, D.C.         |  |
| 100. SIGNATURE OF REGISTRAR<br>J. Edgar Hoover             |  | 101. SIGNATURE OF DECEASED<br>J. Edgar Hoover |  | 102. SIGNATURE OF WITNESSES<br>J. Edgar Hoover |  |

BUREAU V. S.

DEC 10 1956

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The funeral director, after this certificate has been signed by the attending physician and completely filled in, should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12470

12499

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

|   |                              |   |  |
|---|------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Frederick</u> MARYLAND  |                              | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>                |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Rural - Woodstock</u>  |                              | c. LENGTH OF STAY IN 1b<br><u>25 yrs</u>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>-</u>  |                              | d. STREET ADDRESS<br><u>Rural - Woodstock</u>   |  |
| 3. NAME OF DECEASED<br>(Type or print) <u>LAWRENCE CASPER MEHRLING</u>  |                              | 4. DATE OF DEATH<br>Month <u>Dec.</u> Day <u>21</u> Year <u>1956</u>  |  |
| 5. SEX<br><u>M</u>  | 6. COLOR OR RACE<br><u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>Sept. 1, 1897</u> |
| 9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Laborer</u>  |                              | 9b. AGE (In years last birthday)<br><u>59</u> yrs.  |  |
| 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Of - Fibre Bank Co.</u>   |                              | 11. BIRTHPLACE (State or foreign country)<br><u>Maryland</u>  |  |
| 13. FATHER'S NAME<br><u>Casper Mehrling</u>   |                              | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |  |
| 14. MOTHER'S MAIDEN NAME<br><u>Betty Eyles</u>  |                              | 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) <u>No</u>   |  |
| 16. SOCIAL SECURITY NO.<br><u>214-10-3501</u>   |                              | 17. INFORMANT<br><u>Mrs. Marlin Shiner, Woodstock</u>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u><br>331X DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u><br>DUE TO<br>(c) _____ |                              | INTERVAL BETWEEN ONSET AND DEATH<br><u>3 days</u>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____   |                              |   |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |                              |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)  |                              | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. p. m. <u>19</u>  |                              | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                              | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <u>Mr.</u> , 19 <u>56</u> to <u>Dec 21</u> , 19 <u>56</u> that I last saw the deceased alive on <u>Dec 20</u> , 19 <u>56</u> , and that death occurred at <u>10:00</u> M., from the causes and on the date stated above.  |                              |   |  |
| ACTUAL SIGNATURE<br><u>J. H. Measler</u>  |                              | M.D. <u>Johnsville Md Dec 21</u>  |  |
| PHYSICIAN'S NAME (Type)<br><u>J. H. Measler</u>   |                              |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |                              | 22b. DATE THEREOF<br><u>12/24/56</u>  |  |
| 22c. NAME OF CEMETERY OR CREMATORY<br><u>Rocky Hill Cemetery</u>  |                              | 22d. LOCATION (City, town, or county) (State)<br><u>W. Woodstock Md.</u>  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Y. C. Barton</u>   |                              | ADDRESS<br><u>Walkerville, Md.</u>  |  |
| 24a. REC'D BY REGISTRAR<br>DATE <u>24 Dec 1956</u>  |                              | 24b. REGISTRAR'S SIGNATURE<br><u>Elizabeth S. Heck</u>  |  |

CERTIFICATE OF DEATH

*[Faint, mostly illegible text from the reverse side of the document is visible through the paper. Discernible words include "DEATH", "CAUSE", "PLACE", "DATE", "SIGNATURE", and "REGISTERED".]*

BUREAU V. S.

DEC 27 1956

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12471

## CERTIFICATE OF DEATH

Reg. Dist. No.

12471

|  |                                  |   |   |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Frederick</b> MARYLAND   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>                |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Frederick</b>   |                                  | c. LENGTH OF STAY IN 1b<br><b>Lifetime</b>  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>116 East 6th Street</b>   |                                  | d. STREET ADDRESS<br><b>116 East 6th Street</b>   |   |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                  |   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Dora</b> Middle <b>E.</b> Last <b>Morgan</b>   |                                  | 4. DATE OF DEATH<br>Month <b>December</b> Day <b>31</b> Year <b>1956</b>  |   |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>June 27-1884</b> |
| 9. AGE (In years lost birthday)<br><b>70</b> yrs.  |                                  | IF UNDER 1 YEAR<br>Months Days Hours Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Seamstress</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Tailoring Co.</b>   |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   |
| 13. FATHER'S NAME<br><b>Harry Knipple</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Mary Cramer</b>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>219-03-5543</b>   |   |
| 17. INFORMANT<br><b>Mrs. John E. Staley-Hagerstown-Md. (daughter)</b>  |                                  | Address   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b><br><b>420.1</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO<br>(c) DUE TO  |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>minutes</b>  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY<br>Hour o. m. p. m. Month, Day, Year<br><b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)  |   |
| 21. I certify that I attended the deceased from <b>Dec. 15, 1956</b> , to <b>Dec. 31, 1956</b> , that I last saw the deceased alive on <b>Dec. 15, 1956</b> , and that death occurred at <b>3 A.</b> M., from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>Watkins Acres- Frederick-Md.</b> DATE SIGNED <b>1/31/57</b> |                                  |   |   |
| ACTUAL SIGNATURE <b>B. Thomas</b>  |                                  | M.D. <b>Watkins Acres- Frederick-Md.</b>  |   |
| PHYSICIAN'S NAME (Type) <b>Dr. B.O. Thomas-Sr.</b>   |                                  |   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 22b. DATE THEREOF<br><b>Jan. 3-1957</b>   |   |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Olivet Cemetery</b>   |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>Frederick- Maryland</b>   |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>C. E. Clement &amp; Son</b>   |                                  | ADDRESS<br><b>Frederick, Maryland</b>   |   |
| 24a. REC'D BY REGISTRAR<br>DATE <b>2 Jan 1957</b>  |                                  | 24b. REGISTRAR'S SIGNATURE<br><b>Elizabeth B. Hanks</b>   |   |

CERTIFICATE OF DEATH

|                        |  |                        |  |                      |  |
|------------------------|--|------------------------|--|----------------------|--|
| Name of Deceased       |  | Sex                    |  | Age                  |  |
| John Doe               |  | Male                   |  | 45                   |  |
| Date of Death          |  | Place of Death         |  | Cause of Death       |  |
| Jan 3, 1957            |  | Baltimore, Md.         |  | Heart Disease        |  |
| Signature of Physician |  | Signature of Registrar |  | Signature of Coroner |  |
| [Signature]            |  | [Signature]            |  | [Signature]          |  |

BUREAU Y. A

JAN 3 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12472  
131

12500

CERTIFICATE OF DEATH

Reg. Dist. No.

|  |                                  |  |   |  |  |   |   |
|--|----------------------------------|--|---|--|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Frederick</b> MARYLAND   |                                  |  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b> |  |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Frederick-Rural RD#4</b>  |                                  |  |   | c. LENGTH OF STAY IN 1b<br><b>Years</b>  |  |   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Ballenger Creek Road</b>  |                                  |  |   | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>ELLIE</b> Middle <b>BERNICE</b> Last <b>MYERS</b>  |                                  |  |   | 4. DATE OF DEATH<br>Month <b>December 1,</b> Day <b>1956</b>   |  |   |   |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>19 Nov 1872</b>  |  | 9. AGE (In years last birthday)<br><b>84</b> yrs.                      | IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.                  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>House-work</b>   |                                  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>At Home</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>           |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |
| 13. FATHER'S NAME<br><b>William Henry Howard</b>   |                                  |  |   | 14. MOTHER'S MAIDEN NAME<br><b>Ellen Rebecca Culler</b>  |  |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>None</b>   |   | 17. INFORMANT Address<br><b>Mrs. George R. Bell (Same As Item #1)</b>  |  |   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Chronic Congestive failure + uremia</b><br><b>420.0</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Auricular fibrillation</b><br>DUE TO (c) <b>Arterio-sclerotic heart dis.</b> |                                  |  |   |  |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 week</b><br><b>1 month</b><br><b>4 yrs.</b>              |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Severe Senile asthenia</b>  |                                  |  |   |  |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)              |  |  |   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. <b>9.</b> p. m. <b>19</b>  |                                  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |   | 20f. (City or town) (County) (State)  |
| 21. I certify that I attended the deceased from <b>1948</b> to <b>1 DEC</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>1 DEC</b> , 19 <b>56</b> , and that death occurred at <b>12:25A</b> M, from the causes and on the date stated above.   |                                  |  |   |  |  |   |   |
| ACTUAL SIGNATURE <b>Charles H. Conley, Jr.</b> M.D.  |                                  |  |   | ADDRESS (Street, city or town, state) DATE SIGNED<br><b>228 N. Market St., Frederick, Md. 12/3/56</b>  |  |   |   |
| PHYSICIAN'S NAME (Type) <b>Charles H. Conley, Jr., M.D.</b>  |                                  |  |   |  |  |   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 22b. DATE THEREOF<br><b>4 Dec 1956</b>   |   | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Mount Olivet Cemetery</b>   |  | 22d. LOCATION (City, town, or county) (State)<br><b>Frederick, Maryland</b> |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>M. R. Etchison &amp; Son, Frederick, Maryland</b>   |                                  |  |   | ADDRESS  |  | 24a. REC'D BY REGISTRAR<br>DATE <b>3 DEC 1956</b>                           |   |
|  |                                  |  |   | 24b. REGISTRAR'S SIGNATURE<br><b>Elizabeth G. Hack</b>   |  |   |   |



12501

## CERTIFICATE OF DEATH

Reg. Dist. 12473

|   |                                    |  |  |
|---|------------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>FREDERICK</u> MARYLAND  |                                    | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>b. STATE <u>MARYLAND</u> b. COUNTY <u>FREDERICK</u> |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>WALKERSVILLE</u>   |                                    | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>WALKERSVILLE</u>                                      |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>RURAL</u>  |                                    | d. STREET ADDRESS<br><u>RURAL</u>  |  |
| 3. NAME OF DECEASED (Type or print) First Middle Last<br><u>SARAH ELIZABETH OREM</u>  |                                    | 4. DATE OF DEATH Month Day Year<br><u>DEC. 26 1956</u>   |  |
| 5. SEX<br><u>FEMALE</u>   | 6. COLOR OR RACE<br><u>COLORED</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <u>DIVIDED</u>                  | 8. DATE OF BIRTH<br><u>JAN. 3-1852</u> |
| 9. AGE (In years last birthday)<br><u>104</u> yrs.  |                                    | IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>DOMESTIC</u>  |                                    | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>HOUSEKEEPER</u>  |  |
| 11. BIRTHPLACE (State or foreign country)<br><u>MARYLAND</u>  |                                    | 12. CITIZEN OF WHAT COUNTRY?<br><u>U. S.</u>   |  |
| 13. FATHER'S NAME<br><u>FRANK DORSEY</u>  |                                    | 14. MOTHER'S MAIDEN NAME<br><u>HARRIETT P</u>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><u>NO</u>   |                                    | 16. SOCIAL SECURITY NO.<br><u>NONE</u>   |  |
| 17. INFORMANT<br><u>HARRY OREM - WALKERSVILLE, MD</u>   |                                    | Address  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pneumonia, Old Age</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |                                    |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                    | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m.<br>19  |                                    | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work                                       |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                    | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <u>1945</u> , 19 <u>56</u> , to <u>1956</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Dec 10</u> , 19 <u>56</u> , and that death occurred at <u>2:10 PM</u> , from the causes and on the date stated above.   |                                    |  |  |
| ACTUAL SIGNATURE <u>Ea M. Beall</u>   |                                    | ADDRESS (Street, city or town, state) DATE SIGNED <u>Dec. 26/56</u>  |  |
| PHYSICIAN'S NAME (Type) <u>IRA W. BEALL M. D.</u>   |                                    | <u>LIBERTYTOWN, MD.</u>  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>  |                                    | 22b. DATE THEREOF<br><u>12/29/56</u>   |  |
| 22c. NAME OF CEMETERY OR CREMATORY<br><u>WESLEY CEM.</u>  |                                    | 22d. LOCATION (City, town, or county) (State)<br><u>LIBERTYTOWN MD.</u>  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>DD Hutcherson Sons, Libertytown, Md</u>  |                                    | 24a. REC'D BY REGISTRAR<br><u>DATE 12-31-56</u>  |  |
| 24b. REGISTRAR'S SIGNATURE<br><u>Elizabeth Heck</u>   |                                    |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

|  |  |   |  |
|--|--|---|--|
| <p>1. Name of deceased: <b>JOHN J. WAVE</b></p>                              |  | <p>2. Date of death: <b>DEC 31 1956</b></p>               |  |
| <p>3. Place of death: <b>HOME</b></p>  |  | <p>4. Age: <b>68</b></p>                                  |  |
| <p>5. Sex: <b>M</b></p>  |  | <p>6. Race: <b>W</b></p>                                  |  |
| <p>7. Marital status: <b>M</b></p>   |  | <p>8. Occupation: <b>RETIRED</b></p>                      |  |
| <p>9. Cause of death: <b>HEART DISEASE</b></p>                               |  | <p>10. Immediate cause: <b>MYOINFARCTION</b></p>          |  |
| <p>11. Contributing causes: <b>HYPERTENSION, CORONARY ARTERY DISEASE</b></p> |  | <p>12. Duration of illness: <b>2 WEEKS</b></p>            |  |
| <p>13. Name of physician: <b>DR. J. H. SMITH</b></p>                         |  | <p>14. Name of hospital: <b>JOHN HOPKINS HOSPITAL</b></p> |  |
| <p>15. Name of funeral home: <b>JOHN J. WAVE</b></p>                         |  | <p>16. Name of cemetery: <b>GREENWOOD CEMETERY</b></p>    |  |
| <p>17. Name of informant: <b>JOHN J. WAVE</b></p>                            |  | <p>18. Signature of informant: <b>[Signature]</b></p>     |  |
| <p>19. Name of registrar: <b>JOHN J. WAVE</b></p>                            |  | <p>20. Signature of registrar: <b>[Signature]</b></p>     |  |

**RECEIVED**  
**DEC 31 1956**  
**BUREAU V. 3**

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12502

## CERTIFICATE OF DEATH

Reg. Dist. No. 12474

|  |  |   |   |
|--|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Frederick</b> MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MD</b> b. COUNTY <b>Frederick</b>                      |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Thurmont</b>  |  | c. LENGTH OF STAY IN 1b<br><b>50 yrs</b>  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Thurmont</b> |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION   |  | d. STREET ADDRESS   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>LILLIE</b> Middle <b>MAY</b> Last <b>POOLE</b>   |  | 4. DATE OF DEATH<br>Month <b>Dec.</b> Day <b>29th</b> Year <b>1956</b>  |   |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b>         | 7. MARRIED <input checked="" type="checkbox"/> NEVER-MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Jan. 8. 1876</b>   |
| 9. AGE (In years last birthday)<br><b>80</b>   |  | IF UNDER 1 YEAR<br>Months Days Hours Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>House wife</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>  | 11. BIRTHPLACE (State or foreign country)<br><b>Fredk. Co. MD</b>                                   |
| 13. FATHER'S NAME<br><b>Frank I. Portner</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>Sophia Davis</b>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>  |  | 16. SOCIAL SECURITY NO.<br><b>No</b>  |   |
| 17. INFORMANT<br><b>Mrs Mary Stull Thurmont</b>  |  | Address <b>MD</b>   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b><br><b>332X</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral Arteriosclerosis</b><br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Fracture of hip - old</b> |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>4 wks</b><br><b>3 yrs</b>                                    |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                              |
| 20f. (City or town)  |  | (County) (State)  |   |
| 21. I certify that I attended the deceased from <b>Dec. 1 -</b> , 19 <b>56</b> , to <b>Dec. 27</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>Dec. 27</b> , 19 <b>56</b> , and that death occurred at <b>8 A.</b> M., from the causes and on the date stated above.   |  |   |   |
| ACTUAL SIGNATURE<br><b>James K. Gray</b>   |  | ADDRESS (Street, city or town, state) <b>Thurmont - Md.</b>   |   |
| PHYSICIAN'S NAME (Type)<br><b>James K. Gray. Thurmont MD</b>   |  | DATE SIGNED   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 22b. DATE THEREOF<br><b>Dec 31. 1956</b> | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Lewistown Cem.</b>   | 22d. LOCATION (City, town, or county) (State)<br><b>Lewistown Fredk. Co. Md</b>                     |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Raymond C. Greager</b>  |  | ADDRESS<br><b>Thurmont, MD</b>  |   |
| 24a. REC'D BY REGISTRAR<br><b>DATE 31 Dec 1956</b>   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Elizabeth B. Hech</b>  |   |



# 1 12472 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 13

12475

|  |                           |  |                                       |
|--|---------------------------|--|---------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <i>Frederick</i> MARYLAND   |                           | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <i>Maryland</i> b. COUNTY <i>Frederick</i>             |                                       |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Frederick</i>  |                           | c. LENGTH OF STAY IN 1b <i>1 da</i>  |                                       |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Frederick Memorial Hosp.</i>   |                           | d. STREET ADDRESS <i>Thurmont</i>  |                                       |
| 3. NAME OF DECEASED (Type or print) <i>NELLIE MARGARET</i>   |                           | 4. DATE OF DEATH <i>Dec. 1 1956</i>  |                                       |
| 5. SEX <i>F</i>  | 6. COLOR OR RACE <i>W</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>Nov. 16. 1899</i> |
| 9. AGE (In years last birthday) <i>57</i> yrs.   |                           | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.  |                                       |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>  |                           | 10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>  |                                       |
| 11. BIRTHPLACE (State or foreign country) <i>Thurmont</i>  |                           | 12. CITIZEN OF WHAT COUNTRY <i>U.S.A</i>   |                                       |
| 13. FATHER'S NAME <i>Joseph E. Wilhide</i>   |                           | 14. MOTHER'S MAIDEN NAME <i>Lillie M. Freeze</i>   |                                       |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give war or dates of service) <i>No</i>   |                           | 16. SOCIAL SECURITY NO. <i>No</i>  |                                       |
| 17. INFORMANT <i>Wm. S. Pryor Sr.</i> Address <i>Thurmont. MD.</i>   |                           |  |                                       |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Infection of brain</i><br>420.0 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Occlusion of left cerebral artery due to embolus</i><br>DUE TO (c) <i>arteriosclerotic heart disease with mural thrombi in right and left auricular appendages</i> |                           | INTERVAL BETWEEN ONSET AND DEATH<br><i>3 days</i><br><i>3 yrs</i>  |                                       |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                           | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                                       |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                           | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                       |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <i>19</i>   |                           | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work   |                                       |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                           | 20f. (City or town) (County) (State)   |                                       |
| 21. I certify that I attended the deceased from <i>11/29</i> , 1956, to <i>12/1</i> , 1956, that I last saw the deceased alive on <i>12/1</i> , 1956, and that death occurred at <i>11:30 A.M.</i> from the causes and on the date stated above.   |                           |  |                                       |
| ACTUAL SIGNATURE <i>Henry V. Chase</i> M.D.  |                           | ADDRESS (Street, city or town, state) <i>4 E. Church St</i> DATE SIGNED <i>12/1/56</i>   |                                       |
| PHYSICIAN'S NAME (Type) <i>Henry V. Chase</i>  |                           | <i>Frederick Maryland</i>  |                                       |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>  |                           | 22b. DATE THEREOF <i>Dec. 3. 1956</i>  |                                       |
| 22c. NAME OF CEMETERY OR CREMATORY <i>United Brethren Cem.</i>   |                           | 22d. LOCATION (City, town, or county) (State) <i>Thurmont. Fredk Co MD</i>   |                                       |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Raymond B. Creager</i> ADDRESS <i>Thurmont MD</i>  |                           | 24a. REC'D BY REGISTRAR DATE <i>5 Dec. 1956</i>  |                                       |
|  |                           | 24b. REGISTRAR'S SIGNATURE <i>Elizabeth B. Hecker</i>  |                                       |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

|                                    |  |                        |  |  |  |  |  |  |  |
|------------------------------------|--|------------------------|--|--|--|--|--|--|--|
| NAME OF DECEASED<br>JOHN W. WILSON |  | SEX<br>MALE            |  | RACE<br>WHITE                          |  | DATE OF BIRTH<br>NOV. 10, 1899         |  | PLACE OF BIRTH<br>BALTIMORE, MD.       |  |
| RESIDENCE<br>1234 E. BALTIMORE ST. |  | OCCUPATION<br>LABORER  |  | CAUSE OF DEATH<br>HEART DISEASE        |  | MANNER OF DEATH<br>NATURAL             |  | TIME OF DEATH<br>10:30 A.M.            |  |
| DATE OF DEATH<br>DEC. 5, 1956      |  | PLACE OF DEATH<br>HOME |  | SIGNATURE OF PHYSICIAN<br>J. W. WILSON |  | SIGNATURE OF REGISTRAR<br>J. W. WILSON |  | SIGNATURE OF WITNESSES<br>J. W. WILSON |  |
| COUNTY<br>BALTIMORE                |  | CITY<br>BALTIMORE      |  | STATE<br>MARYLAND                      |  | YEAR<br>1956                           |  | MONTH<br>DEC.                          |  |

BUREAU V. S.

DEC 6 1956

RECEIVED

RECEIVED



1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12476

## CERTIFICATE OF DEATH

12503

Reg. Dist. No. 81

|  |                              |  |                                      |  |                                |  |                                |
|--|------------------------------|--|--------------------------------------|--|--------------------------------|--|--------------------------------|
| <b>1. PLACE OF DEATH</b>   |                              |  |                                      | <b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>   |                                |  |                                |
| COUNTY <i>Frederick</i>  |                              | MARYLAND   |                                      | STATE <i>Maryland</i>  |                                | COUNTY <i>Frederick</i>  |                                |
| CITY (If outside corporate limits, write RURAL and give nearest town)<br><i>Union Bridge</i>   |                              | LENGTH OF STAY (in this place)<br><i>Life</i>                          |                                      | CITY (If outside corporate limits, write RURAL and give nearest town)<br><i>Union Bridge</i> |                                |  |                                |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS  |                              |  |                                      | STREET ADDRESS<br><i>Rt. 2</i>   |                                | (If rural give location)   |                                |
| <b>3. NAME OF DECEASED</b><br>(Type or Print) <i>Fannie Diehl</i> (First) <i>Reff</i> (Middle) <i>Reff</i> (Last)  |                              |  |                                      | <b>4. DATE OF DEATH</b><br>12 - 3 - 1956   |                                |  |                                |
| 5. SEX<br><i>Female</i>  | 6. COLOR OR RACE<br><i>W</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)<br><i>Widowed</i>     | 8. DATE OF BIRTH<br><i>2-19-1868</i> | 9. AGE last birthday<br><i>88</i> yrs.   | IF UNDER 1 YEAR<br>Months Days |  | IF UNDER 24 HRS.<br>Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>House Wife</i>   |                              | 10b. KIND OF BUSINESS OR INDUSTRY                                      |                                      | 11. BIRTHPLACE (State or foreign country)<br><i>Frederick Co. Md</i>                         |                                | 12. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A</i>                       |                                |
| 13. FATHER'S NAME<br><i>John H. Diehl</i>  |                              |  |                                      | 14. MOTHER'S MAIDEN NAME<br><i>Hannah Clouty</i>   |                                |  |                                |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)  |                              | 16. SOCIAL SECURITY NO.  |                                      | 17. INFORMANT & ADDRESS<br><i>John S. Reff</i>   |                                |  |                                |
| <b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>  |                              |  |                                      | <b>18. MEDICAL CERTIFICATION</b>   |                                |  |                                |
| 331X IMMEDIATE CAUSE (A) <i>Cerebral Hemorrhage</i>  |                              |  |                                      | INTERVAL BETWEEN ONSET AND DEATH   |                                |  |                                |
| ANTECEDENT CAUSE(S) DUE TO (B) <i>Arterio Sclerosis</i>  |                              |  |                                      |  |                                |  |                                |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)   |                              |  |                                      |  |                                |  |                                |
| 11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.   |                              |  |                                      |  |                                |  |                                |
| 19a. DATE OF OPERATION   |                              | 19b. MAJOR FINDINGS OF OPERATION                                       |                                      | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                     |                                |  |                                |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                              | 21b. PLACE (Home, farm, lactory, OF INJURY street, office bldg., etc.) |                                      | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)                                 |                                |  |                                |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |                              | 21e. INJURY OCCURRED   |                                      | 21f. HOW DID INJURY OCCUR?   |                                |  |                                |
| 22. I hereby certify that I attended the deceased from <i>Jan 4</i> , 1956, to <i>Dec 3</i> , 1956, that I last saw the deceased alive on <i>12-3-</i> , 1956, and that death occurred at <i>2:30</i> M, from the causes and on the date stated above. |                              |  |                                      |  |                                |  |                                |
| SIGNATURE <i>J. N. Legg</i>  |                              |  |                                      | ADDRESS (Street, city, town, state) <i>Union Bridge Md</i> DATE SIGNED <i>12-4-56</i>        |                                |  |                                |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>  |                              | DATE THEREOF<br><i>12-5-56</i>   |                                      | NAME OF CEMETERY OR CREMATORY<br><i>Beaver Dam</i>   |                                | LOCATION (City, town, or county) (State)<br><i>Union Bridge Md</i> |                                |
| 24. REC'D BY REGISTRAR<br><i>12/4/56</i>   |                              | REGISTRAR'S SIGNATURE<br><i>Leah J. Reff</i>                           |                                      | 25. FUNERAL DIRECTOR'S SIGNATURE<br><i>Raymond K. Wright</i>                                 |                                | ADDRESS  |                                |

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

1956

REG. NO. 115

11703

1. USUAL RESIDENCE OF DECEASED

2. DATE OF DEATH

MARYLAND

COUNTY OF BALTIMORE

3. PLACE OF DEATH

4. CAUSE OF DEATH

5. MANNER OF DEATH

6. SEX

7. AGE

8. OCCUPATION

9. EDUCATION

10. MARITAL STATUS

11. PREVIOUS ILLNESS

12. PREVIOUS SURGERY

13. PREVIOUS TRAUMA

14. PREVIOUS DRUGS

15. PREVIOUS ALCOHOL

16. PREVIOUS TOBACCO

17. PREVIOUS OTHER

18. PREVIOUS OTHER

19. PREVIOUS OTHER

20. PREVIOUS OTHER

21. PREVIOUS OTHER

22. PREVIOUS OTHER

23. PREVIOUS OTHER

24. PREVIOUS OTHER

25. PREVIOUS OTHER

26. PREVIOUS OTHER

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30. PREVIOUS OTHER

31. PREVIOUS OTHER

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42. PREVIOUS OTHER

43. PREVIOUS OTHER

44. PREVIOUS OTHER

45. PREVIOUS OTHER

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47. PREVIOUS OTHER

48. PREVIOUS OTHER

49. PREVIOUS OTHER

50. PREVIOUS OTHER

BUREAU V. S.

DEC 11 1956

RECEIVED

Reg. Dist. No.

|  |                                  |   |  |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Frederick</b><br><b>MARYLAND</b>   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b><br>b. COUNTY <b>Frederick</b>             |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Frederick</b>   |                                  | c. LENGTH OF STAY IN 1b<br><b>Years</b>   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br>OR INSTITUTION<br><b>Frederick Memorial Hospital</b>  |                                  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <b>JESSE</b> Middle <b>JAMES</b> Last <b>RIPPEON</b>   |                                  | 4. DATE OF DEATH<br>Month <b>December</b> Day <b>22</b> Year <b>1956</b>  |  |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>18 May 1884</b>   |
| 9. AGE (In years last birthday)<br><b>72</b> yrs.  |                                  | 10. IF UNDER 1 YEAR<br>Months <b>72</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>  | 11. IF UNDER 24 HRS.<br>Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired Supt.</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Country Club</b>  |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 13. FATHER'S NAME<br><b>Zacharias Rippeon</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Mary Wilson</b>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) <b>No</b><br>(If yes, give war or dates of service)  |                                  | 16. SOCIAL SECURITY NO.<br><b>577-26-8013</b>   |  |
| 17. INFORMANT<br><b>Mrs. Carrie Crum Rippeon</b>   |                                  | Address<br><b>(Same as item #2)</b>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b><br>331x DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>arterio sclerosis</b><br>DUE TO<br>(c) <b>5 days</b><br><b>5 yrs +</b> |                                  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                                  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY<br>Hour <b>a. p.</b> Month <b>19</b> Day <b>19</b> Year <b>1956</b>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <b>Dec. 22, 1956</b> to <b>Dec. 22, 1956</b> , that I last saw the deceased alive on <b>Dec. 22, 1956</b> , and that death occurred at <b>10 P</b> M, from the causes and on the date stated above.  |                                  |   |  |
| ACTUAL SIGNATURE <b>B. O. Thomas</b>   |                                  | ADDRESS (Street, city or town, state) <b>228 N. Market St., Frederick, Md.</b><br>DATE SIGNED <b>12/24/56</b>   |  |
| PHYSICIAN'S NAME (Type) <b>B. O. Thomas, M. D.</b>   |                                  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 22b. DATE THEREOF<br><b>26 Dec 1956</b>   |  |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Mount Olivet Cemetery</b>   |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>Frederick, Maryland</b>   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>M. R. Etchison &amp; Son, Frederick, Maryland</b>   |                                  | ADDRESS<br><b>24a. REC'D BY REGISTRAR</b><br>DATE <b>26 Dec 1956</b><br><b>24b. REGISTRAR'S SIGNATURE</b><br><b>Elizabeth G. Heck</b>                       |  |

CERTIFICATE OF DEATH

|                   |  |                                |  |                |  |                                |  |                |  |                        |  |                        |  |                                |  |                                |  |                        |  |                                |  |
|-------------------|--|--------------------------------|--|----------------|--|--------------------------------|--|----------------|--|------------------------|--|------------------------|--|--------------------------------|--|--------------------------------|--|------------------------|--|--------------------------------|--|
| Name of Deceased  |  | Sex                            |  | Age            |  | Date of Birth                  |  | Place of Birth |  | Usual Residence        |  | Cause of Death         |  | Place of Death                 |  | Time of Death                  |  | Signature of Physician |  | Signature of Registrar         |  |
| JAMES J. JONES    |  | Male                           |  | 25             |  | 1930                           |  | Maryland       |  | 120 West 34th Street   |  | Tuberculosis           |  | Tuberculosis Memorial Hospital |  | 12:30 PM                       |  | J. Jones, M.D.         |  | J. Jones, M.D.                 |  |
| Date of Death     |  | Place of Death                 |  | Cause of Death |  | Place of Death                 |  | Time of Death  |  | Signature of Physician |  | Signature of Registrar |  | Date of Death                  |  | Place of Death                 |  | Cause of Death         |  | Place of Death                 |  |
| December 28, 1956 |  | Tuberculosis Memorial Hospital |  | Tuberculosis   |  | Tuberculosis Memorial Hospital |  | 12:30 PM       |  | J. Jones, M.D.         |  | J. Jones, M.D.         |  | December 28, 1956              |  | Tuberculosis Memorial Hospital |  | Tuberculosis           |  | Tuberculosis Memorial Hospital |  |

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DEC 28 1956  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12478

12504

## CERTIFICATE OF DEATH

Reg. Dist. No.

|   |  |   |  |  |  |   |  |
|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH<br>o. COUNTY <u>Frederick</u> MARYLAND  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>             |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Rural - Mt. Airy</u>   |  |   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Rural - Mt Airy</u>   |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>Home - Rt 1 - Mt. Airy</u>   |  |   |  | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>George</u> Middle <u>Ezra</u> Last <u>Routzahn</u>  |  |   |  | 4. DATE OF DEATH<br>Month <u>December</u> Day <u>15</u> Year <u>1956</u>   |  |   |  |
| 5. SEX<br><u>Male</u>   |  | 6. COLOR OR RACE<br><u>white</u>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>Dec. 5, 1900</u>                                   |  |
| 9. AGE (In years last birthday)<br><u>56</u> yrs.   |  | IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u> |  | IF UNDER 24 HRS.<br>Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>   |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Laborer</u>   |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Farm</u>   |  | 11. BIRTHPLACE (State or foreign country)<br><u>Maryland</u>              |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.</u>   |  |   |  |  |  |   |  |
| 13. FATHER'S NAME<br><u>Enos Sasser Routzahn</u>  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><u>Alice Biser</u>   |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)   |  |   |  | 16. SOCIAL SECURITY NO.<br><u>216-05-9813</u>  |  | 17. INFORMANT<br><u>Mrs. George E. Routzahn - Mt Airy</u>                 |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Cerebral Thrombosis, Hemiparesis,</u><br>DUE TO<br><u>Invalidism</u><br>(c) <u>  </u> |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>Immediate</u><br><u>3 years</u>   |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |   |  |  |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. <u>  </u> p. m. <u>19</u>   |  |   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)    |  |
| 20f. (City or town)<br><u>  </u>  |  |   |  | 20g. (County)<br><u>  </u>   |  | 20h. (State)<br><u>  </u>   |  |
| 21. I certify that I attended the deceased from <u>Dec. 29, 1953</u> , to <u>Dec. 15, 1956</u> , that I last saw the deceased alive on <u>June 15, 1956</u> , and that death occurred at <u>8:30 P.M.</u> from the causes and on the date stated above.   |  |   |  |  |  |   |  |
| ACTUAL SIGNATURE <u>W.B. Culwell</u>  |  |   |  | ADDRESS (Street, city or town, state) <u>Mt. Airy, Md.</u>   |  |   |  |
| DATE SIGNED <u>12/15/56</u>   |  |   |  |  |  |   |  |
| PHYSICIAN'S NAME (Type) <u>W.B. Culwell</u>   |  |   |  |  |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |  | 22b. DATE THEREOF<br><u>12/18/1956</u>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><u>E.H.B. Cem. Pleasant Walk</u>   |  | 22d. LOCATION (City, town, or county) (State)<br><u>Frederick Co. Md.</u> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Gladhill Co. Middletown, Md.</u>   |  |   |  | 24a. REC'D BY REGISTRAR<br>DATE <u>12-18-56</u>  |  | 24b. REGISTRAR'S SIGNATURE<br><u>Lucian Falcov</u>                        |  |



# CERTIFICATE OF DEATH

1957

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

BUREAU V. 3

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|   |  |  |  |
|---|--|--|--|
| <p>1. Name of deceased (Print name and last name)<br/>                 _____</p>                      |  | <p>2. Sex<br/>                 _____</p>   |  |
| <p>3. Date of birth (Month, day, year)<br/>                 _____</p>                                 |  | <p>4. Place of birth (City, State, Country)<br/>                 _____</p>   |  |
| <p>5. Date of death (Month, day, year)<br/>                 _____</p>                                 |  | <p>6. Place of death (City, State, Country)<br/>                 _____</p>   |  |
| <p>7. Cause of death (List all causes, beginning with immediate cause)<br/>                 _____</p> |  | <p>8. Manner of death (Select one)<br/>                 Natural _____<br/>                 Accidental _____<br/>                 Suicide _____<br/>                 Homicide _____<br/>                 Undetermined _____</p> |  |
| <p>9. Signature of physician (Print name)<br/>                 _____</p>                              |  | <p>10. Signature of registrar (Print name)<br/>                 _____</p>  |  |
| <p>11. Date of registration (Month, day, year)<br/>                 _____</p>                         |  | <p>12. Place of registration (City, State, Country)<br/>                 _____</p>   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12479

12505

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH<br>o. COUNTY <b>Frederick</b> MARYLAND  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>                |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Adamstown-Rural RD#1</b>   |  | c. LENGTH OF STAY IN 1b<br><b>31 years</b>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Adamstown-Rural RD#1</b>   |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Near Adamstown</b>   |  |  |  | d. STREET ADDRESS<br><b>Near Adamstown</b>  |  | e. IS RESIDENCE ON A FARM?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 3. NAME OF DECEASED<br>(Type or print) First Middle Last<br><b>OTHO SCOTT</b>   |  |  |  | 4. DATE OF DEATH<br>Month Day Year<br><b>December 1, 1956</b>   |  |   |  |
| 5. SEX<br><b>Male</b>   |  | 6. COLOR OR RACE<br><b>Colored</b>   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>Unknown</b>  |  |
| 9. AGE (In years last birthday)<br><b>58</b> yrs.   |  | IF UNDER 1 YEAR<br>Months Days Hours Min.  |  | IF UNDER 24 HRS.<br>Hours Min.  |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Laborer</b>   |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Farm</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Virginia</b>                                      |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |  |  |   |  |   |  |
| 13. FATHER'S NAME<br><b>William Scott</b>   |  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Martha Timbers</b>   |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) <b>No</b>   |  | (If yes, give war or dates of service)   |  | 16. SOCIAL SECURITY NO.<br><b>217-305-519</b>   |  | 17. INFORMANT<br><b>3730 N. 18th St.,<br/>Ralph F. Scott, Philadelphia 40, Pa.</b>                |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b><br><b>443X</b> DUE TO <b>Hypertensive Cardiovascular disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>?</b><br>(c) <b>?</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Myocarditis</b><br>INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs</b> |  |  |  |   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |
| 20c. TIME OF INJURY<br>Hour a. p. m. <b>19</b>  |  | 20d. INJURY OCCURRED<br>White <input type="checkbox"/> Nat white <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <b>11/29, 1956</b> , to <b>12/1, 1956</b> , that I last saw the deceased alive on <b>11/29, 1956</b> , and that death occurred at <b>8 A</b> M, from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>Jefferson, Maryland</b> DATE SIGNED <b>3 Dec 1956</b>   |  |  |  |   |  |   |  |
| ACTUAL SIGNATURE <b>A. P. Brice</b> M.D.  |  |  |  | DATE SIGNED <b>3 Dec 1956</b>   |  |   |  |
| PHYSICIAN'S NAME (Type) <b>A. Talbott Brice, M. D.</b>  |  |  |  |   |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 22b. DATE THEREOF<br><b>4 Dec 1956</b>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Sunnyside Methodist Cem.</b>   |  | 22d. LOCATION (City, town, or county) (State)<br><b>Frederick County Maryland</b>                 |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>M. R. Etchison &amp; Son, Frederick, Maryland</b>  |  |  |  | 24a. REC'D BY REGISTRAR<br>DATE <b>4 Dec 1956</b>   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Elizabeth S. Heck</b>  |  |

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BUREAU V. 3

|                            |  |                |  |                  |  |
|----------------------------|--|----------------|--|------------------|--|
| NAME (Last, First, Middle) |  | DATE OF BIRTH  |  | SEX              |  |
| JAMES EARL RAY             |  | APR 14 1928    |  | MALE             |  |
| RACE                       |  | COLOR          |  | RELIGION         |  |
| WHITE                      |  | WHITE          |  | METHODIST        |  |
| EDUCATION                  |  | SCHOOLING      |  | MILITARY SERVICE |  |
| HIGH SCHOOL                |  | 11 YEARS       |  | NONE             |  |
| OCCUPATION                 |  | RESIDENCE      |  | CITY             |  |
| NONE                       |  | MEMPHIS, TENN. |  | MEMPHIS, TENN.   |  |
| MARRIAGE                   |  | MARRIAGE       |  | MARRIAGE         |  |
| NONE                       |  | NONE           |  | NONE             |  |
| SIGNATURE                  |  | DATE           |  | PLACE            |  |
| JAMES EARL RAY             |  | APR 14 1928    |  | MEMPHIS, TENN.   |  |

*James Earl Ray*  
*Staff Sergeant*

12506

## CERTIFICATE OF DEATH

12480

Reg. Dist. No. 138

|  |  |  |  |
|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>FREDERICK</u> MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>MARYLAND</u> b. COUNTY <u>FREDERICK</u> |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>RURAL FREDERICK</u> |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>NEW MARKET</u>  |  |
| c. LENGTH OF STAY IN 1b<br><u>4 HOURS</u>  |  | d. STREET ADDRESS  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION                               |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |

|   |                              |   |   |  |   |  |  |
|---|------------------------------|---|---|--|---|--|--|
| 3. NAME OF DECEASED (Type or print) First Middle Last<br><u>HOWARD BERNARD SELBY</u>                                    |                              |   |   | 4. DATE OF DEATH Month Day Year<br><u>December 10 1956</u>   |   |  |  |
| 5. SEX<br><u>M</u>  | 6. COLOR OR RACE<br><u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>FEB 2 - 1896</u> | 9. AGE (In years last birthday)<br><u>60</u> yrs.            | IF UNDER 1 YEAR<br>Months Days Hours Min. | IF UNDER 24 HRS.                           |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>STATION ATTENDANT</u> |                              | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>GASOLINE</u>  |   | 11. BIRTHPLACE (State or foreign country)<br><u>MARYLAND</u> |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u> |  |

|  |  |  |  |
|--|--|--|--|
| 13. FATHER'S NAME<br><u>HOWARD C. SELBY</u>                                      |  | 14. MOTHER'S MAIDEN NAME<br><u>MARY C. HOBBS</u> |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><u>YES</u> |  | 16. SOCIAL SECURITY NO.<br><u>216-30-3712</u>    |  |
| 17. INFORMANT<br><u>MRS ANN SELBY (WIFE)</u>                                     |  | Address<br><u>NEW MARKET MD</u>                  |  |

|  |  |  |
|--|--|--|
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u><br>DUE TO<br><u>1-18-1919</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <u>Chronic Myocarditis -</u><br>DUE TO<br>(c) _____ |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>Immediate more than 2 years</u> |
|--|--|--|

|   |  |  |
|---|--|--|
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
|---|--|--|

|  |  |  |                                      |
|--|--|--|--------------------------------------|
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |                                      |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. 19  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                       | 20f. (City or town) (County) (State) |

|   |  |
|---|--|
| 21. I certify that I attended the deceased from <u>August</u> 19 <u>55</u> , to <u>Nov.</u> 19 <u>56</u> , that I last saw the deceased alive on <u>Nov. 1</u> 19 <u>56</u> , and that death occurred at <u>2:00 P.M.</u> from the causes and on the date stated above. |  |
| ADDRESS (Street, city or town, state) DATE SIGNED<br><u>W.B. Culwell</u> M.D. <u>mt. airy, maryland</u> <u>12/11/56</u>   |  |
| PHYSICIAN'S NAME (Type)   |  |

|  |   |  |  |
|--|---|--|--|
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u> | 22b. DATE THEREOF<br><u>DEC-13-1956</u> | 22c. NAME OF CEMETERY OR CREMATORY<br><u>MOUNT OLIVE CEM</u> | 22d. LOCATION (City, town, or county) (State)<br><u>FREDERICK MD</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>W. E. Falconer</u>  |   | ADDRESS<br><u>New Market Md</u>                              | 24a. REC'D BY REGISTRAR<br><u>Lucian K. Falconer</u>                 |
|  |   | DATE<br><u>Dec 12-56</u>                                     | 24b. REGISTRAR'S SIGNATURE   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12481

12471

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

|   |                                  |   |   |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH<br>o. COUNTY <b>Frederick</b> MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>                |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Frederick</b>  |                                  | c. LENGTH OF STAY IN 1b<br><b>Lifetime</b>  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Frederick Memorial Hospital</b>  |                                  | d. STREET ADDRESS<br><b>326 East Patrick Street</b>   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>CHARLES</b> Middle <b>WILLIAM</b> Last <b>SHAW</b>  |                                  | 4. DATE OF DEATH<br>Month <b>December</b> Day <b>2</b> Year <b>1956</b>   |   |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>October 14, 1883</b> |
| 9. AGE (In years last birthday) <b>73</b> yrs.  |                                  | IF UNDER 1 YEAR<br>Months Days Hours Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Dyer</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Hosiery</b>   |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |   |
| 13. FATHER'S NAME<br><b>Samuel Shaw</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Alice Null</b>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)   |                                  | 16. SOCIAL SECURITY NO.<br><b>214-10-1138A</b>  |   |
| 17. INFORMANT<br><b>Mrs. Charles W. Shaw - 326 E. Patrick Street</b>  |                                  | Address <b>Frederick, Md.</b>   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b><br><b>420.0</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cerebral Thrombosis</b><br>DUE TO (c) <b>Arteriosclerotic Heart Disease</b> |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>10 Days</b><br><b>11 Days</b><br><b>3 months</b>   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                  |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. p. m. <b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)  |   |
| 21. I certify that I attended the deceased from <b>June 1, 1954</b> , to <b>Dec 2, 1957</b> , that I last saw the deceased alive on <b>Dec 2, 1957</b> , and that death occurred at <b>5:15 PM</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED<br><b>12-4-57</b>   |                                  |   |   |
| ACTUAL SIGNATURE <b>Thomas E. Stone</b> M.D.  |                                  |   |   |
| PHYSICIAN'S NAME (Type) <b>Dr. Thomas E. Stone</b>  |                                  | <b>4 West Third Street- Frederick-Md.</b>   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 22b. DATE THEREOF<br><b>Dec. 5, 1956</b>  |   |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Mount Olivet Cemetery</b>  |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>Frederick, Maryland</b>   |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>C. E. Clineson - Frederick Md.</b>   |                                  | 24a. REC'D BY REGISTRAR<br><b>DATE 4 Dec 1956</b>   |   |
|   |                                  | 24b. REGISTRAR'S SIGNATURE<br><b>Elizabeth G. Heck</b>  |   |

BUREAU V. S.

DEC 6 1956

RECEIVED

12475

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

|  |                                  |   |   |  |  |   |   |
|--|----------------------------------|---|---|--|--|---|---|
| 1. PLACE OF DEATH<br>o. COUNTY <b>Frederick</b> MARYLAND   |                                  |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b> |  |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Frederick</b>   |                                  |   | c. LENGTH OF STAY IN 1b<br><b>Life</b>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Frederick</b> |   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Frederick Memorial Hospital</b>   |                                  |   |   | d. STREET ADDRESS<br><b>227 Washington Street</b>  |  |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>GEORGE WILLIAM SHIPLEY</b>  |                                  |   |   | 4. DATE OF DEATH<br>Month Day Year<br><b>December 20, 1956</b>   |  |   |   |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>September 9, 1875</b>  |  | 9. AGE (In years last birthday) yrs.<br><b>81</b>  | IF UNDER 1 YEAR<br>Months Days Hours Min.                                   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Partner</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Bottling Works</b>  |   | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                  |   |
| 13. FATHER'S NAME<br><b>William H. Shipley</b>   |                                  |   |   | 14. MOTHER'S MAIDEN NAME<br><b>Mary E. Kettler</b>   |  |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>214-10-5604</b>   |   | 17. INFORMANT Address<br><b>Mrs. Elizabeth M. Shipley, same as item 2</b>  |  |   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Congestive Cardiac</b><br><b>591x</b> DUE TO <b>acute pulmonary edema</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>arterio sclerosis</b><br>DUE TO <b>parenchymatous nephritis</b><br>(c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ |                                  |   |   |  |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>5/20x</b>  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  |   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>   |                                  |   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                               |   | 20f. (City or town) (County) (State)  |
| 21. I certify that I attended the deceased from <b>Dec. 19, 1956</b> , to <b>Dec. 20, 1956</b> , that I last saw the deceased alive on <b>Dec. 19, 1956</b> , and that death occurred at <b>8:55 A.M.</b> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>Professional Bldg., Frederick, Md.</b> DATE SIGNED <b>12/21/56</b><br>ACTUAL SIGNATURE <b>B. O. Thomas</b> M.D.<br>PHYSICIAN'S NAME (Type) <b>Dr. B. O. Thomas Sr.</b> Same as above   |                                  |   |   |  |  |   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 22b. DATE THEREOF<br><b>Dec. 24, 1956</b>   |   | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Mount Olivet Cemetery</b>   |  | 22d. LOCATION (City, town, or county) (State)<br><b>Frederick, Maryland</b> |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>M. R. Etchison &amp; Son, Frederick, Maryland</b>   |                                  |   |   | 24a. REC'D BY REGISTRAR<br><b>DATE 21 Dec. 1956</b>  |  | 24b. REGISTRAR'S SIGNATURE<br><b>Elizabeth G. Hark</b>                      |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 5

DEC 26 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 FilmG209 1-1-57 et

## CERTIFICATE OF DEATH

12483

Reg. Dist. No.

131

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Frederick</u> MARYLAND  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> ✓              |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>   |  |  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 27</u>  |  |  |  |
| c. LENGTH OF STAY IN 1b <u>10 days</u>  |  |  |  | d. STREET ADDRESS <u>3404 Hopkins Ave</u>   |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick Memorial Hosp.</u>  |  |  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |
| 3. NAME OF DECEASED (Type or print) <u>Harper</u> First <u>Joshua G</u> Middle <u>Shipley</u> Last <u>Shipley</u>   |  |  |  | 4. DATE OF DEATH <u>Dec 26 1956</u> Month <u>Dec</u> Day <u>26</u> Year <u>1956</u>   |  |  |  |
| 5. SEX <u>M</u>   |  | 6. COLOR OR RACE <u>W</u>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>    |  | 8. DATE OF BIRTH <u>Apr 25 1880</u> yrs. <u>76</u>                               |  |
| 9. AGE (In years last birthday) <u>76</u> yrs.  |  | IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u> |  | IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>   |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Rot Watchman</u>   |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>Howard Co Md</u>   |  | 11. BIRTHPLACE (State or foreign country) <u>Howard Co Md</u>                    |  |
| 12. CITIZEN OF WHAT COUNTRY? <u>  </u>  |  |  |  |   |  |  |  |
| 13. FATHER'S NAME <u>Oliver Shipley</u>   |  |  |  | 14. MOTHER'S MAIDEN NAME <u>Margaret Shipley</u>  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>  </u> (If yes, give war or dates of service) <u>  </u>   |  |  |  | 16. SOCIAL SECURITY NO. <u>  </u>   |  |  |  |
| 17. INFORMANT <u>Norman Downing-811 Chapelgate Lane</u> Address <u>  </u>   |  |  |  |   |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u><br><u>422.1</u> DUE TO (b) <u>  </u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>  </u><br>DUE TO (b) <u>  </u><br>DUE TO (c) <u>  </u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>2 Malnutrition</u> <u>3 Bunchy pneumonia bilateral</u><br>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  |   |  |  |  |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>  |  |  |  |   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>   |  |  |  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u> |  |
| 20f. (City or town) <u>  </u> (County) <u>  </u> (State) <u>  </u>  |  |  |  |   |  |  |  |
| 21. I certify that I attended the deceased from <u>12/16</u> , 19 <u>56</u> , to <u>12/26</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>12/26</u> , 19 <u>56</u> , and that death occurred at <u>5:45 P.M.</u> from the causes and on the date stated above.  |  |  |  |   |  |  |  |
| ACTUAL SIGNATURE <u>Henry V Chase</u> M.D. <u>4 E. Church St</u> ADDRESS (Street, city or town, state) <u>Frederick Md</u> DATE SIGNED <u>12/26/56</u>  |  |  |  |   |  |  |  |
| PHYSICIAN'S NAME (Type) <u>Henry V Chase</u>  |  |  |  |   |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |  | 22b. DATE THEREOF <u>12/29/56</u>  |  | 22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cem.</u>   |  | 22d. LOCATION (City, town, or county) (State) <u>Glen Burnie Md</u>              |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm Cook Sme-1217 St Paul St</u> ADDRESS <u>  </u>   |  |  |  | 24a. REC'D BY REGISTRAR <u>DEC 27 1956</u>  |  | 24b. REGISTRAR'S SIGNATURE <u>Ely Hicks</u>                                      |  |



RECEIVED

DEC 27 1956

BUREAU V. S.

|                                |  |                              |  |
|--------------------------------|--|------------------------------|--|
| NAME OF DECEASED               |  | DATE OF DEATH                |  |
| PLACE OF DEATH                 |  | CITY AND STATE               |  |
| OCCUPATION                     |  | EDUCATION                    |  |
| MARRIAGE                       |  | RELIGION                     |  |
| CAUSE OF DEATH                 |  | MANNER OF DEATH              |  |
| SIGNATURE OF DECEASED          |  | SIGNATURE OF WITNESS         |  |
| SIGNATURE OF PHYSICIAN         |  | SIGNATURE OF CLERGYMAN       |  |
| SIGNATURE OF JUDGE             |  | SIGNATURE OF NOTARY          |  |
| SIGNATURE OF CORONER           |  | SIGNATURE OF SHERIFF         |  |
| SIGNATURE OF DISTRICT ATTORNEY |  | SIGNATURE OF COUNTY CLERK    |  |
| SIGNATURE OF TOWNSHIP CLERK    |  | SIGNATURE OF VILLAGE CLERK   |  |
| SIGNATURE OF POSTMASTER        |  | SIGNATURE OF SCHOOL CLERK    |  |
| SIGNATURE OF CHURCH CLERK      |  | SIGNATURE OF SYNAGOGUE CLERK |  |
| SIGNATURE OF MOSQUE CLERK      |  | SIGNATURE OF TEMPLE CLERK    |  |
| SIGNATURE OF OTHER CLERK       |  | SIGNATURE OF OTHER CLERK     |  |

WESTLAND STATE DEPARTMENT OF HEALTH—BUREAU OF VITALS  
CERTIFICATE OF DEATH

12477

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Frederick</u> MARYLAND   |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <u>MD.</u> b. COUNTY <u>Frederick</u>                  |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Frederick</u>   |  |  |  | c. LENGTH OF STAY IN 1b<br><u>3 days</u>   |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>Frederick Memorial Hospital</u>   |  |  |  | d. STREET ADDRESS<br><u>MT Airy - Route 1</u>  |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Caroline</u> Middle <u>-</u> Last <u>Showns</u>  |  |  |  | 4. DATE OF DEATH<br>Month <u>Dec.</u> Day <u>9</u> Year <u>1956</u>  |  |  |  |
| 5. SEX<br><u>F</u>   |  | 6. COLOR OR RACE<br><u>W</u>   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>1867</u>  |  |
| 9. AGE (In years last birthday)<br><u>89</u> yrs.  |  | IF UNDER 1 YEAR<br>Months <u>89</u> Days <u>9</u> Hours <u>1</u> Min. <u>0</u> |  | IF UNDER 24 HRS.<br>Months <u>89</u> Days <u>9</u> Hours <u>1</u> Min. <u>0</u>  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>House wife</u>   |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>-</u>  |  | 11. BIRTHPLACE (State or foreign country)<br><u>Virginia</u>                       |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.</u>  |  |  |  |  |  |  |  |
| 13. FATHER'S NAME<br><u>Mr. - STROOP</u>   |  |  |  | 14. MOTHER'S MAIDEN NAME<br><u>-</u>   |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><u>No</u>  |  |  |  | 16. SOCIAL SECURITY NO.<br><u>-</u>  |  | 17. INFORMANT <u>MRS. James KINGMAN</u> Address <u>MT. Airy, Md.</u><br>(Daughter) |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral vascular accident</u><br>DUE TO <u>420.0</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Senility</u><br>DUE TO (c) <u>Arterio sclerotic heart disease</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>-</u> |  |  |  |  |  |  |  |
| INTERVAL BETWEEN ONSET AND DEATH<br><u>3 days</u><br><u>years</u><br><u>1 yr</u>   |  |  |  |  |  |  |  |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <u>19</u>   |  |  |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)             |  |
| 20f. (City or town) (County) (State)   |  |  |  |  |  |  |  |
| 21. I certify that I attended the deceased from <u>Dec. 6</u> , 19 <u>56</u> , to <u>Dec 9</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Dec 8</u> , 19 <u>56</u> , and that death occurred at <u>6:15</u> M, from the causes and on the date stated above.  |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE <u>Rex R Martin</u> M.D.  |  |  |  | ADDRESS (Street, city or town, state) <u>35 E. Church Frederick Md</u> DATE SIGNED <u>12-9-56</u>  |  |  |  |
| PHYSICIAN'S NAME (Type) <u>Rex R Martin</u>  |  |  |  |  |  |  |  |
| 22a. BURIAL, CREMATION, REBURY (Specify)<br><u>Burial</u>  |  | 22b. DATE THEREOF<br><u>12-12-56</u>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Cedar Grove Cemetery</u>  |  | 22d. LOCATION (City, town, or county) (State)<br><u>Mt. Jackson - Va.</u>          |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>C. E. Clune &amp; Son</u>   |  |  |  | ADDRESS<br><u>Frederick - Md.</u>  |  | 24a. REC'D BY REGISTRAR<br><u>Elizabeth G. Heck</u>                                |  |
| 24b. REGISTRAR'S SIGNATURE   |  |  |  |  |  |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MEDICAL CERTIFICATION

VS A15 (4)  
15M 9/55

RECEIVED  
JAN 31 1955  
BUREAU V. S.



12478

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

131

|   |                              |   |  |  |   |  |  |
|---|------------------------------|---|--|--|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Frederick</b> MARYLAND  |                              |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b> |   |  |  |
| b. CITY OR <del>TOWN</del> (If outside corporate limits, write RURAL and give nearest town)<br><b>Frederick <del>Memorial</del></b>   |                              |   |  | c. LENGTH OF STAY IN 1b<br><b>Frederick, R.F.D 6</b>   |   |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Frederick Memorial Hoppital</b>  |                              |   |  | d. STREET ADDRESS<br><b>Frederick, R.F.D 6</b>   |   |  |  |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                              |   |  |  |   |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Richard Eugene</b> Middle <b>Tourtellotte</b> Last <b>Tourtellotte</b>  |                              |   |  | 4. DATE OF DEATH<br>Month <b>December</b> Day <b>30</b> Year <b>19 56</b>  |   |  |  |
| 5. SEX<br><b>M</b>  | 6. COLOR OR RACE<br><b>W</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER-MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>June 15, 1916</b> |  | 9. AGE (In years last birthday)<br><b>40</b> yrs. | IF UNDER 1 YEAR<br>Months Days Hours Min.                        |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |                              | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Providence, R.I.</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                    |  |
| 13. FATHER'S NAME<br><b>George Albert Tourtellotte</b>  |                              |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Mary Hurley</b>   |   |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)  |                              | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service)  |  | 17. INFORMANT<br><b>Beulah Louise Tourtellotte</b>   |   | Address <b>Frederick, Md R.F.D 6</b>                             |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>General <del>peritonitis</del></b><br><b>541.1</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Perforated Doudenal ulcer</b><br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |                              |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>4 days ?</b><br><b>5 days ?</b>   |   |  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |                              |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m. <b>19</b>   |                              | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |   | 20f. (City or town) (County) (State)                             |  |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .                              |                              |   |  |  |   |  |  |
| ACTUAL SIGNATURE <b>B.O. Thomas</b>   |                              |   |  | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |   |  |  |
| EXAMINER'S NAME (Type) <b>B.O. Thomas</b>   |                              |   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |   |  |  |
|   |                              |   |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |   |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal</b>   |                              |   |  | 22b. DATE THEREOF<br><b>Jan. 1, 1957</b>   |   | 22c. NAME OF CEMETERY OR CREMATORY<br><b>St. Mary's Cemetery</b> |  |
|   |                              |   |  | 22d. LOCATION (City, town, or county)<br><b>Avon, Connecticut</b>  |   | (State)  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>CECline Dan RW8</b>  |                              |   |  | ADDRESS<br><b>Frederick, Maryland</b>  |   | 24a. REC'D BY REGISTRAR<br><b>DATE 31 Dec 1956</b>               |  |
|   |                              |   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Elizabeth B. Hech</b>   |   |  |  |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

## BUREAU V.

12508

## CERTIFICATE OF DEATH

Reg. Dist. No.

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Frederick</b> MARYLAND  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>                |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Rural Fairfield, Pa.</b>   |  |  |  | c. LENGTH OF STAY IN 1b<br><b>47 yrs.</b>   |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Fairfield, RD.# 1 Pa.</b>  |  |  |  | e. STREET ADDRESS<br><b>Fairfield, Pa. R.D.#1</b>   |  |   |  |
| 3. NAME OF DECEASED<br>(Type or print) <b>Cora Adela Tressler</b>   |  |  |  | 4. DATE OF DEATH <b>December 23 1956</b>  |  |   |  |
| 5. SEX<br><b>Female</b>   |  | 6. COLOR OR RACE<br><b>White</b>   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>Sept, 3, 1872</b>  |  |
| 9. AGE (In years last birthday) <b>84</b> yrs.  |  | IF UNDER 1 YEAR  |  | IF UNDER 24 HRS.  |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>--</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Adams County, Pa.</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 13. FATHER'S NAME<br><b>John Linebaugh</b>  |  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Sarah Ann Harshman</b>   |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) <b>no</b>   |  | 16. SOCIAL SECURITY NO.<br><b>None</b>   |  | 17. INFORMANT<br>Address  |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardio renal disease</b><br><b>442x</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arterio Sclerosis</b><br>DUE TO (c) <b>Advanced Age</b> |  |  |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 yr.</b><br><b>?</b>                                      |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |  |  |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. p. m. <b>19</b>  |  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work of work |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <b>Dec. 16, 1956</b> , to <b>Dec. 23, 1956</b> , that I last saw the deceased alive on <b>Dec. 23, 1956</b> , and that death occurred at <b>7: A M.</b> from the causes and on the date stated above.   |  |  |  |   |  |   |  |
| ACTUAL SIGNATURE <b>Ira M. Henderson</b> M.D.   |  |  |  | ADDRESS (Street, city or town, state) <b>Fairfield, Penna.</b>  |  |   |  |
| DATE SIGNED <b>12-23-56</b>   |  |  |  |   |  |   |  |
| PHYSICIAN'S NAME (Type) <b>Dr. Ira M. Henderson</b>   |  |  |  |   |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |  | 22b. DATE THEREOF <b>12/26/1956</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY <b>St. Jacobs</b>  |  | 22d. LOCATION (City, town, or county) (State) <b>Fairfield RD#1 Adams Co. Pa.</b>                 |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>S. L. Allison</b>  |  |  |  | ADDRESS<br><b>Fairfield, Pa.</b>  |  | 24a. REC'D BY REGISTRAR<br>DATE <b>12-28-1956</b>   |  |
|   |  |  |  | 24b. REGISTRAR'S SIGNATURE<br><b>Ely. Heck</b>  |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Of

rescritto nel 1871

- تا بهمدومین سال، و بعد از آن در هر دو سال یکبار

BUREAU V. S.

DEC 28 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12488

12509

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

|  |  |   |  |  |  |   |  |
|--|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>FREDERICK</b> MARYLAND   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MD</b> b. COUNTY <b>FREDERICK</b>                   |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BRADDOCK HEIGHTS</b>   |  |   |  | c. LENGTH OF STAY IN 1b <b>4 DAYS</b>  |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>WINDY BONA NURSING HOME</b>  |  |   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |
| 3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>LAVINIA</b> Last <b>URNER</b>  |  |   |  | 4. DATE OF DEATH Month <b>DEC</b> Day <b>2</b> Year <b>1956</b>  |  |   |  |
| 5. SEX <b>FEMALE</b>   |  | 6. COLOR OR RACE <b>WHITE</b>   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <b>FEB. 16 1872</b> 84 yrs.                      |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (State or foreign country) <b>SOUTH CAROLINA</b>  |  | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>                        |  |
| 13. FATHER'S NAME <b>JOSEPH W FLOYD</b>  |  |   |  | 14. MOTHER'S MAIDEN NAME <b>HARRIET F. PETTIT</b>  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>   |  | 16. SOCIAL SECURITY NO. <b>---</b>  |  | 17. INFORMANT <b>JOSEPH W. URNER FREDERICK MD</b> Address  |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b><br><b>331X</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause (b) <b>Hypertension</b><br>lying cause (c) <b>Atherosclerosis</b> |  |   |  |  |  | INTERVAL BETWEEN ONSET AND DEATH <b>2 mo.</b>                     |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>---</b>   |  |   |  |  |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. p. m. <b>---</b> <b>19</b>   |  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)                              |  |
| 21. I certify that I attended the deceased from <b>Jan 1</b> , 1956, to <b>Dec 2</b> , 1956, that I last saw the deceased alive on <b>Nov 28</b> , 1956, and that death occurred at <b>2:54</b> A.M. from the causes and on the date stated above.   |  |   |  |  |  |   |  |
| ACTUAL SIGNATURE <b>A. A. Pearce</b> M.D.  |  |   |  | DATE SIGNED <b>Fredrick, Md</b>  |  |   |  |
| PHYSICIAN'S NAME (Type) <b>---</b>   |  |   |  |  |  |   |  |
| 22a. BURIAL, CREMATION, or other disposal (Specify) <b>BURIAL</b>  |  | 22b. DATE THEREOF <b>12/4/56</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY <b>MT. OLIVET</b>   |  | 22d. LOCATION (City, town, or county) (State) <b>FREDERICK MD</b> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>Clarence C. Gentry</b> ADDRESS <b>Fredrick Md</b>  |  |   |  | 24a. REC'D BY REGISTRAR <b>---</b> DATE <b>3 Dec 1956</b>  |  | 24b. REGISTRAR'S SIGNATURE <b>Elizabeth G. Hecks</b>              |  |



Bureau of Prisons  
 Dec 20/20 Wt. Clivet  
 Frederick Md

RECEIVED  
 DEC 7 1956  
 BUREAU V. 3

Joseph W. Turner Frederick Md  
 Joseph W. Floyd  
 Harriet F. Pettit  
 South Carolina U.S.A.  
 Female White  
 Mary  
 Lavinia Turner  
 DEC 2 20  
 210 East 2nd St  
 Frederick Md

Frederick  
 4 days  
 210 East 2nd St  
 Frederick Md  
 Frederick

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**12479**  
**CERTIFICATE OF DEATH**

**12489**

Reg. Dist. No. **131**

|  |  |   |  |   |   |  |   |  |  |
|--|--|---|--|---|---|--|---|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <b>Frederick</b> <span style="float: right;">MARYLAND</span>   |  |   |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> <span style="float: right;">b. COUNTY <b>Frederick</b></span>  |   |  |   |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Frederick</b>   |  |   | c. LENGTH OF STAY IN 1b<br><b>Lifetime</b>   |   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Frederick</b> |   |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>122 East Seventh Street</b>   |  |   |  | d. STREET ADDRESS<br><b>122 East Seventh Street</b>   |   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| <b>3. NAME OF DECEASED</b><br>(Type or print)<br>First <b>OLIVIA</b> Middle <b>M.</b> Last <b>WELLER</b>   |  |   |  | <b>4. DATE OF DEATH</b><br>Month <b>December</b> Day <b>7</b> Year <b>19 56</b>   |   |  |   |  |  |
| <b>5. SEX</b><br><b>Female</b>   |  | <b>6. COLOR OR RACE</b><br><b>White</b>       |  | <b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER-MARRIED</b> <input type="checkbox"/><br><b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/> |   | <b>8. DATE OF BIRTH</b><br><b>December 11, 1857</b>  |   | <b>9. AGE</b> (In years last birthday) <b>98</b> yrs.<br>IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____<br>IF UNDER 24 HRS. _____ |  |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |  |   | <b>10b. KIND OF BUSINESS OR INDUSTRY</b><br><b>Own home</b>  |   | <b>11. BIRTHPLACE</b> (State or foreign country)<br><b>Maryland</b>           |  |   | <b>12. CITIZEN OF WHAT COUNTRY?</b><br><b>U.S.A.</b>   |  |
| <b>13. FATHER'S NAME</b><br><b>Alfred Staley</b>   |  |   |  | <b>14. MOTHER'S MAIDEN NAME</b><br><b>Susan Shook</b>   |   |  |   |  |  |
| <b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b><br>(Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)  |  | <b>16. SOCIAL SECURITY NO.</b><br><b>None</b> |  | <b>17. INFORMANT</b><br>Address <b>Mr. Frank A. Weller - Mount Airy, Maryland</b>   |   |  |   |  |  |
| <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Chronic Myocarditis</b><br><b>422.2</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____   |  |   |  |   |   |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>7 1/2</b>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Intertrochanteric fracture right hip.</b>   |  |   |  |   |   |  |   | <b>19. WAS AUTOPSY PERFORMED?</b><br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| <b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)  |  |   |  | <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)   |   |  |   |  |  |
| <b>20c. TIME OF INJURY</b> Month, Day, Year<br>Hour a. m. _____ p. m. <b>19</b>  |  |   | <b>20d. INJURY OCCURRED</b><br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |   | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) |  | <b>20f. (City or town)</b> _____ (County) _____ (State) _____                                     |  |  |
| <b>21. I certify that I attended the deceased from</b> <b>Dec. 6, 1956</b> , <b>to</b> <b>Dec. 7, 1956</b> , <b>that I last saw the deceased</b> <b>olive on Dec 6, 1956</b> , <b>and that death occurred at</b> <b>5:30 P.M.</b> , <b>from the causes and on the date stated above.</b><br><b>ADDRESS (Street, city or town, state)</b> <b>Frederick Md. 12/8/56</b> <b>DATE SIGNED</b> |  |   |  |   |   |  |   |  |  |
| <b>ACTUAL SIGNATURE</b> <b>H. F. Kline</b> <b>M.D.</b>   |  |   |  | <b>PHYSICIAN'S NAME (Type)</b> <b>Dr. H. F. Kline</b> <b>7 North Market Street - Frederick, Maryland</b>  |   |  |   |  |  |
| <b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b><br><b>Buried</b>  |  |   | <b>22b. DATE THEREOF</b><br><b>12/10/56</b>  |   | <b>22c. NAME OF CEMETERY OR CREMATORY</b><br><b>Mount Olivet Cemetery</b>     |  |   | <b>22d. LOCATION (City, town, or county)</b> <b>Frederick, Maryland</b> (State) _____  |  |
| <b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>W. C. E. Cline &amp; Son</b> <b>Frederick - Md.</b>   |  |   |  | <b>24a. REC'D BY REGISTRAR</b><br><b>DATE</b> <b>11 Dec. 1956</b>   |   | <b>24b. REGISTRAR'S SIGNATURE</b><br><b>Elizabeth G. Heck</b>  |   |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18  
 3478  
 CERTIFICATE OF DEATH

|  |  |  |  |
|--|--|--|--|
| NAME OF DECEASED<br>Frederick            |  | LAST NAME<br>Frederick                   |  |
| DATE OF BIRTH<br>1927                    |  | PLACE OF BIRTH<br>Frederick              |  |
| 132 East Seventh Street                  |  | 132 East Seventh Street                  |  |
| BALTIMORE, MARYLAND                      |  | BALTIMORE, MARYLAND                      |  |
| DATE OF DEATH<br>December 11, 1956       |  | PLACE OF DEATH<br>Frederick              |  |
| HOMECOMING                               |  | HOMECOMING                               |  |
| ALLIED STATES                            |  | ALLIED STATES                            |  |
| ST. FRANK A. HOTEL - BALTIMORE, MARYLAND |  | ST. FRANK A. HOTEL - BALTIMORE, MARYLAND |  |
| BUREAU V. 2                              |  | BUREAU V. 2                              |  |
| DEC 12 1956                              |  | DEC 12 1956                              |  |
| RECEIVED                                 |  | RECEIVED                                 |  |

1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# 12480 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 CERTIFICATE OF DEATH

Reg. Dist. No.

12490

|  |                                  |   |   |  |  |   |   |
|--|----------------------------------|---|---|--|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Frederick</b> MARYLAND   |                                  |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b> |  |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Frederick</b>   |                                  | c. LENGTH OF STAY IN 1b<br><b>30 years</b>  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Frederick</b>   |  |   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Frederick Memorial Hospital</b>   |                                  |   |   | d. STREET ADDRESS<br><b>506 North Bentz Street</b>   |  |   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>CHARLES</b> Middle <b>WESLEY</b> Last <b>WETZEL</b>  |                                  |   |   | 4. DATE OF DEATH<br>Month <b>December</b> Day <b>22</b> Year <b>19 56</b>  |  |   |   |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>February 4, 1880</b> |  | 9. AGE (In years last birthday) <b>76</b> yrs. |   | IF UNDER 1 YEAR<br>Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Laborer</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Day</b>   |   | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>                                 |   |
| 13. FATHER'S NAME<br><b>Henry Wetzel</b>   |                                  |   |   | 14. MOTHER'S MAIDEN NAME<br><b>Mary Naill</b>  |  |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>214-10-2922</b>   |   | 17. INFORMANT Address<br><b>Mr. Sterling J. Wetzel - Rt. 5, Frederick, Md.</b>   |  |   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>bronchio pneumonia</b><br><b>600.0</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Uremia</b><br>DUE TO (c) <b>Pylonephritis</b> |                                  |   |   |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>days</b><br><b>weeks</b><br><b>yr</b>    |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I  |                                  |   |   |  |  |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  |   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)  |   |
| 21. I certify that I attended the deceased from <b>12/24, 1956</b> , to <b>12/22, 1956</b> , that I last saw the deceased alive on <b>12/24, 1956</b> , and that death occurred at <b>12:45 AM</b> , from the causes and on the date stated above.   |                                  |   |   |  |  |   |   |
| ACTUAL SIGNATURE <b>James B. Thomas</b> M.D.   |                                  |   |   | ADDRESS (Street, city or town, state)<br><b>Frederick, Md.</b>   |  | DATE SIGNED<br><b>12/24/56</b>  |   |
| PHYSICIAN'S NAME (Type)  |                                  |   |   |  |  |   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 22b. DATE THEREOF<br><b>Dec. 24, 1956</b>   |   | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Linganor Cemetery</b>   |  | 22d. LOCATION (City, town, or county) (State)<br><b>Nr. Unionville Maryland</b> |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>W. C. E. Cline &amp; Son - Frederick - Md.</b> ADDRESS   |                                  |   |   | 24a. REC'D BY REGISTRAR<br>DATE <b>24 Dec 1956</b>   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Elizabeth G. Heck</b>                          |   |

CERTIFICATE OF DEATH

15180

|  |  |   |  |  |  |   |  |                                       |  |  |  |
|--|--|---|--|--|--|---|--|---------------------------------------|--|--|--|
| NAME OF DECEASED<br>HARRY ROSS                 |  | AGE<br>40                               |  | SEX<br>Male                                  |  | RACE<br>White                                 |  | DATE OF BIRTH<br>February 1, 1909     |  | PLACE OF BIRTH<br>Maryland                           |  |
| MANNER OF DEATH<br>Natural                     |  | CAUSE OF DEATH<br>Myocardial Infarction |  | IMMEDIATE CAUSE<br>Coronary Thrombosis       |  | DISEASE OR INJURY<br>Coronary Artery Disease  |  | PERIOD OF ILLNESS<br>Several days     |  | PLACE OF DEATH<br>Home                               |  |
| DATE OF DEATH<br>February 15, 1956             |  | TIME OF DEATH<br>10:00 AM               |  | PLACE OF DEATH<br>Home                       |  | RESIDENCE<br>1234 Main Street, Baltimore, Md. |  | OCCUPATION<br>Salesman                |  | EDUCATION<br>High School                             |  |
| SIGNATURE OF PHYSICIAN<br>J. Edgar Smith, M.D. |  | SIGNATURE OF DECEASED<br>Harry Ross     |  | SIGNATURE OF WITNESSES<br>John Doe, Jane Doe |  | SIGNATURE OF FUNERAL HOME<br>ABC Funeral Home |  | SIGNATURE OF COUNTY CLERK<br>Maryland |  | SIGNATURE OF STATE DEPARTMENT OF HEALTH<br>Baltimore |  |

BUREAU V. 3

DEC 27 1956

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12484

## CERTIFICATE OF DEATH

12491

Reg. Dist. No.

|  |                        |  |                             |
|--|------------------------|--|-----------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY Frederick MARYLAND  |                        | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE Maryland b. COUNTY Frederick                           |                             |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 35 Brunswick  |                        | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick 35  |                             |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION II2 West "C"  |                        | d. STREET ADDRESS II2 West "C"   |                             |
| 3. NAME OF DECEASED (Type or print) First Middle Last Walter Christ Wheeler  |                        | 4. DATE OF DEATH Month Day Year I2 5 1956  |                             |
| 5. SEX Male  | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 10-17-1887 |
| 9. AGE (In years last birthday) 69 yrs.  |                        | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.  |                             |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Engineer   |                        | 10b. KIND OF BUSINESS OR INDUSTRY B.&O.R.R.Co  |                             |
| 11. BIRTHPLACE (State or foreign country) Virginia   |                        | 12. CITIZEN OF WHAT COUNTRY? U.S.A.  |                             |
| 13. FATHER'S NAME Anderson Wheeler   |                        | 14. MOTHER'S MAIDEN NAME Lula C. Painter   |                             |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No  |                        | 16. SOCIAL SECURITY NO. 705-10-0003  |                             |
| 17. INFORMANT Mrs. Margaret Wheeler, Brunswick, Md.  |                        | Address  |                             |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 420.2 Engine Failure DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO<br>(c) |                        | INTERVAL BETWEEN ONSET AND DEATH 10 1/2  |                             |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                        |  |                             |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                        | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                             |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19   |                        | 20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>   |                             |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                        | 20f. (City or town) (County) (State)   |                             |
| 21. I certify that I attended the deceased from 12/15/56, 1946, to 12/15/56, 1956, that I last saw the deceased alive on 12/15/56, 1956, and that death occurred at M, from the causes and on the date stated above.   |                        |  |                             |
| ACTUAL SIGNATURE J.G.F. Smith  |                        | ADDRESS (Street, city or town, state) DATE SIGNED 12/15/56   |                             |
| PHYSICIAN'S NAME (Type) J.G.F. Smith   |                        |  |                             |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial   |                        | 22b. DATE THEREOF 12-8-1956  |                             |
| 22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet  |                        | 22d. LOCATION (City, town, or county) (State) Frederick, Maryland  |                             |
| 23. FUNERAL DIRECTOR'S SIGNATURE B. L. Zeit  |                        | ADDRESS Brunswick, Maryland  |                             |
| 24a. REC'D BY REGISTRAR DATE DEC 10 1956   |                        | 24b. REGISTRAR'S SIGNATURE Eugenia Burke   |                             |

CERTIFICATE OF DEATH

|                        |  |                           |  |                        |  |                       |  |                          |  |                    |  |                        |  |                    |  |                      |  |                      |  |                         |  |
|------------------------|--|---------------------------|--|------------------------|--|-----------------------|--|--------------------------|--|--------------------|--|------------------------|--|--------------------|--|----------------------|--|----------------------|--|-------------------------|--|
| NAME OF DECEASED       |  | SEX                       |  | AGE                    |  | DATE OF BIRTH         |  | PLACE OF BIRTH           |  | MARRIAGE           |  | EDUCATION              |  | OCCUPATION         |  | RELIGION             |  | MILITARY SERVICE     |  | SPECIAL SERVICE         |  |
| John Doe               |  | Male                      |  | 45                     |  | 1910                  |  | Maryland                 |  | Married            |  | High School            |  | Teacher            |  | Roman Catholic       |  | None                 |  | None                    |  |
| DATE OF DEATH          |  | PLACE OF DEATH            |  | CAUSE OF DEATH         |  | MANNER OF DEATH       |  | PERIOD OF ILLNESS        |  | PREVIOUS ILLNESS   |  | TREATMENT              |  | HISTORICAL         |  | POSTMORTEM           |  | LABORATORY           |  | OTHER                   |  |
| 1956                   |  | Home                      |  | Heart Disease          |  | Natural               |  | 2 weeks                  |  | None               |  | None                   |  | None               |  | None                 |  | None                 |  | None                    |  |
| SIGNATURE OF PHYSICIAN |  | SIGNATURE OF FUNERAL HOME |  | SIGNATURE OF WITNESSES |  | SIGNATURE OF DECEASED |  | SIGNATURE OF NEXT OF KIN |  | SIGNATURE OF CLERK |  | SIGNATURE OF REGISTRAR |  | SIGNATURE OF JUDGE |  | SIGNATURE OF SHERIFF |  | SIGNATURE OF CORONER |  | SIGNATURE OF PROSECUTOR |  |
| [Signature]            |  | [Signature]               |  | [Signature]            |  | [Signature]           |  | [Signature]              |  | [Signature]        |  | [Signature]            |  | [Signature]        |  | [Signature]          |  | [Signature]          |  | [Signature]             |  |

RECEIVED  
DEC 19 1956  
BUREAU V. 3

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

12492

|  |                                  |   |  |  |   |
|--|----------------------------------|---|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Frederick</b> MARYLAND   |                                  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>482 STATE <b>Chatham St.</b> b. COUNTY <b>Lynn, Massachusetts</b> |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Frederick</b>   |                                  | c. LENGTH OF STAY IN 1b   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Lynn, Massachusetts</b> |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Frederick Memorial Hospital</b>   |                                  |   | d. STREET ADDRESS<br><b>Chatham St.</b>  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) <b>Kenneth D. Wilson</b>   |                                  |   | 4. DATE OF DEATH<br>Month <b>Dec.</b> Day <b>9,</b> Year <b>56</b>   |  |   |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>9/18/22</b>   |  | 9. AGE (In years last birthday)<br><b>33</b> yrs.   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Salesman</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Clark &amp; Cook</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Massachusetts</b>  |   |
| 13. FATHER'S NAME<br><b>Walter Wilson</b>  |                                  |   | 14. MOTHER'S MAIDEN NAME<br><b>Elsie Campbell</b>  |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>Yes</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>2 W.War</b>   |  | 17. INFORMANT<br>Address<br><b>Mrs. Florence A. Wilson, Lynn, Mass</b>   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute pulmonary edema</b><br>816x DUE TO <b>Atelectasis; fractured sternum; cerebral concussion</b><br>Conditions, if any, which gave rise to immediate cause (b) _____<br>(a), stating the underlying cause last. DUE TO (c) _____  |                                  |   |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>5 hrs.</b>   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____  |                                  |   |  |  |   |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>Car ran into back of tractor-trailer</b>                 |  |  |   |
| 20c. TIME OF INJURY<br>Hour <b>2:50</b> o. m. <b>12/7/56</b> p. m.   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>Route #40</b>                     |   |
|  |                                  | 20f. (City or town)<br><b>Carroll</b>   |  | (State)<br><b>Md.</b>  |   |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . |                                  |   |  |  |   |
| ACTUAL SIGNATURE<br><b>B. O. Thomas</b>  |                                  |   | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  |   |
| EXAMINER'S NAME (Type)<br><b>Bernard O. Thomas, M.D.</b>   |                                  |   | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |  |   |
|  |                                  |   | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Shipment</b>   |                                  |   | 22b. DATE THEREOF<br><b>12/10/56</b>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Lynn, Mass</b>   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Dalley's Funeral Home, Fred, Md.</b>  |                                  |   | 24a. REC'D BY REGISTRAR<br>DATE <b>10 Dec 1956</b>   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Elizabeth S. Hach</b>  |

**BUREAU A. S.**

DEC 11 1956

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12493

12482

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Frederick</u> MARYLAND   |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>             |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>  |  |  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>  |  |   |  |
| c. LENGTH OF STAY IN 1b <u>17 years</u>  |  |  |  | d. STREET ADDRESS <u>500 E. Patrick St.</u>  |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION   |  |  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |
| 3. NAME OF DECEASED (Type or print) <u>Amelia Catherine Wolff</u>  |  |  |  | 4. DATE OF DEATH <u>Dec. 21 1956</u>   |  |   |  |
| 5. SEX <u>F</u>  |  | 6. COLOR OR RACE <u>W</u>  |  | 7. MARRIED <input type="checkbox"/> NEVER-MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <u>OCT. 10, 1867</u>   |  |
| 9. AGE (In years last birthday) <u>89 yrs.</u>   |  | IF UNDER 1 YEAR  |  | IF UNDER 24 HRS.   |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>   |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>  |  | 11. BIRTHPLACE (State or foreign country) <u>HANOVER PENNA.</u>  |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>                                    |  |
| 13. FATHER'S NAME <u>Elisha Blocher</u>  |  |  |  | 14. MOTHER'S MAIDEN NAME <u>Catherine Forney</u>   |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>   |  | 16. SOCIAL SECURITY NO. <u>NONE</u>  |  | 17. INFORMANT <u>Mrs. Edna Nell</u> Address <u>500 E. Patrick St. Frederick Md.</u>  |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic myocarditis</u><br><u>422.1</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ |  |  |  |  |  |   | INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs.</u>  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |  |  |  |  |   | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <u>19</u>   |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <u>1936</u> , to <u>Dec 16, 1956</u> , that I last saw the deceased alive on <u>Dec 16, 1956</u> , and that death occurred at <u>3:30 PM</u> from the causes and on the date stated above.   |  |  |  |  |  |   |  |
| ACTUAL SIGNATURE <u>H. F. Kline</u> M.D.   |  |  |  | ADDRESS (Street, city or town, state) <u>7 N. Market St., Frederick, Md.</u> DATE SIGNED <u>Dec 21 1956</u>  |  |   |  |
| PHYSICIAN'S NAME (Type) <u>H. F. Kline, M. D.</u>  |  |  |  |  |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  |  | 22b. DATE THEREOF <u>24 Dec 1956</u>   |  | 22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>  |  | 22d. LOCATION (City, town, or county) (State) <u>HANOVER, YORK CO. PENNA.</u> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>M. R. Etchison &amp; Son, Frederick, Maryland</u> ADDRESS  |  |  |  | 24a. REC'D BY REGISTRAR <u>24 Dec 1956</u>   |  | 24b. REGISTRAR'S SIGNATURE <u>Elizabeth G. Heck</u>                           |  |



BUREAU V. S.

DEC 27 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove-carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12510

## CERTIFICATE OF DEATH

12494

Reg. Dist. No. 131

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Frederick</u> MARYLAND  |  |  |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission)<br>o. STATE <u>MD</u> b. COUNTY <u>FREDERICK</u>   |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL (HARMONY GROVE)</u>  |  |  |  | c. LENGTH OF STAY IN 1b <u>88 yrs</u>   |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>FREDERICK ROUTE 1</u>  |  |  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |
| <b>3. NAME OF DECEASED</b> (Type or print) First <u>MARY</u> Middle <u>WILLETTE</u> Last <u>WORMAN</u>   |  |  |  | <b>4. DATE OF DEATH</b> Month <u>DEC</u> Day <u>19</u> Year <u>1956</u>   |  |  |  |
| <b>5. SEX</b> <u>FEMALE</u>  |  | <b>6. COLOR OR RACE</b> <u>WHITE</u>   |  | <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>   |  | <b>8. DATE OF BIRTH</b> <u>JULY 29 1868</u>                              |  |
| <b>9. AGE</b> (In years last birthday) <u>88</u> yrs.  |  | <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>HOUSE REPAIR</u> |  | <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>MD</u>  |  | <b>11. BIRTHPLACE</b> (State or foreign country) <u>U.S.A</u>            |  |
| <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A</u>   |  |  |  | <b>13. FATHER'S NAME</b> <u>W M D WORMAN</u>  |  |  |  |
| <b>14. MOTHER'S MAIDEN NAME</b> <u>MARY E. GITTERER</u>  |  |  |  | <b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)  |  |  |  |
| <b>16. SOCIAL SECURITY NO.</b> <u>NONE</u>   |  |  |  | <b>17. INFORMANT</b> <u>FAMILY RECORD ROUTE #1</u> Address  |  |  |  |
| <b>18. CAUSE OF DEATH</b> [Enter only one cause per line (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pneumonia</u><br><u>331X</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebrovascular accident</u><br>DUE TO (c) |  |  |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>days</u><br><u>weeks</u>          |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |  |  |   |  |  |  |
| <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  | <b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  |
| <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)  |  |  |  | <b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. <u>19</u> p. m.  |  |  |  |
| <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  |  |  | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)   |  |  |  |
| <b>20f. (City or town)</b> (County) (State)  |  |  |  | <b>21. I certify that I attended the deceased from</b> <u>12/19</u> , 19 <u>56</u> , to <u>12/19</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>12/13</u> , 19 <u>56</u> , and that death occurred at <u>2:30</u> A.M. from the causes and on the date stated above. |  |  |  |
| <b>ACTUAL SIGNATURE</b> <u>James B. Thomas</u> M.D.  |  |  |  | <b>ADDRESS</b> (Street, city or town, state) <u>Frederick, Md.</u>  |  |  |  |
| <b>PHYSICIAN'S NAME</b> (Type)   |  |  |  | <b>DATE SIGNED</b>  |  |  |  |
| <b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>BURIAL</u>   |  | <b>22b. DATE THEREOF</b> <u>12/21/56</u>   |  | <b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>MT. OLIVET</u>   |  | <b>22d. LOCATION</b> (City, town, or county) (State) <u>FREDERICK MD</u> |  |
| <b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>H. C. Carey</u> ADDRESS <u>Frederick, Md.</u>   |  |  |  | <b>24a. REC'D BY REGISTRAR</b>  |  | <b>24b. REGISTRAR'S SIGNATURE</b> <u>Elizabeth S. Heck</u>               |  |

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BUREAU V. S.

1956 76 030

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12511

## CERTIFICATE OF DEATH

Reg. Dist. No. 12495

|   |  |                                   |  |  |  |  |  |
|---|--|-----------------------------------|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Frederick</b> <b>MARYLAND</b>   |  |                                   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>            |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cullen</b>  |  |                                   |  | c. LENGTH OF STAY IN 1b <b>7 days</b>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Big Pool</b> |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Victor Cullen State Hospital</b>  |  |                                   |  | d. STREET ADDRESS <b>21X-2</b>   |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Nellie</b> Middle <b>Zimmerman</b> Last <b>Zimmerman</b>  |  |                                   |  | 4. DATE OF DEATH<br>Month <b>December</b> Day <b>23</b> Year <b>1956</b>   |  |  |  |
| 5. SEX <b>Female</b>  |  | 6. COLOR OR RACE <b>White</b>     |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <b>October 19, 1909</b>   |  |
|   |  |                                   |  | 9. AGE (In years last birthday) <b>47</b> yrs.   |  | 10. IF UNDER 1 YEAR Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unemployed</b>   |  |                                   |  | 10b. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (State or foreign country) <b>Maryland</b>  |  |
|   |  |                                   |  |  |  | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  |
| 13. FATHER'S NAME <b>Charles Kaylor</b>   |  |                                   |  | 14. MOTHER'S MAIDEN NAME <b>Zeta Murray</b>  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)   |  |                                   |  | 16. SOCIAL SECURITY NO. <b>220-16-3598</b>   |  | 17. INFORMANT Address <b>Mrs. Betty Decker, Daughter, Big Pool, Md.</b>                          |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pulmonary Tuberculosis</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>002X</b><br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>INTERVAL BETWEEN ONSET AND DEATH <b>8 yrs.</b> |  |                                   |  |  |  |  |  |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |                                   |  |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |                                   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>  |  |                                   |  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                           |  |
|   |  |                                   |  | 20f. (City or town) (County) (State)   |  |  |  |
| 21. I certify that I attended the deceased from <b>December 16, 1956</b> , to <b>December 23, 1956</b> , that I last saw the deceased alive on <b>December 23, 1956</b> , and that death occurred at <b>8:45 P.M.</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>Cullen, Maryland</b> DATE SIGNED <b>December 23, 1956</b><br>ACTUAL SIGNATURE <b>I. B. Lyon, M.D.</b><br>PHYSICIAN'S NAME (Type) <b>I. B. Lyon, M.D.</b>                      |  |                                   |  |  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |  | 22b. DATE THEREOF <b>12-27-56</b> |  | 22c. NAME OF CEMETERY OR CREMATORY <b>Shanktown Cem.</b>   |  | 22d. LOCATION (City, town, or county) (State) <b>Near-Big Pool, Md.</b>                          |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>John F. Clark Clear Spring, Md</b>  |  |                                   |  | 24a. REC'D BY REGISTRAR DATE <b>12/23/56</b>   |  | 24b. REGISTRAR'S SIGNATURE   |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 31 1956

RECEIVED